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Experts by Experience: ‘Madness’ Narratives, Language, and Politics

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Declaration

I declare that the material presented for examination here is my own work and has not been submitted for an award at this or another Higher Education institution.

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Acknowledgements

To my parents. Thank you for everything. I could not have done this without you.

To Emma. You have been a diligent supervisor, an inspirational mentor, and a cherished friend. I could not have asked for more from you. Thank you for helping me find a voice.

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ABSTRACT

Experts by Experience: 'Madness' Narratives, Language, and Politics

Alexandra Hutchinson

This thesis demonstrates that the historic silencing of those labelled 'mad' is – paradoxically – inextricable from language. Stigma is a semantic issue. The focus of my first chapter is to establish how and when the language available to discuss 'madness' became so problematic. Chapter one establishes a dual language problem: first, the language which surrounds 'madness' is limited and limiting; second, this language imposes social 'otherness', often permanently. I approach the politics of the language of 'madness' using Saussure's hypothesis of signification, Lacan's theory of the *nom du père*, and narrative theory, in order to investigate who is to blame when language and narratives fail.

In chapter two, I examine the reality of these semantic and narrative politics. This chapter covers a variety of 'madness' narratives salvaged from psychiatric textbooks, for example those of influential psychiatrists Emil Kraepelin, Eugen Bleuler and Sigmund Freud. Such texts have been essential to the development of psychiatry, but how have these discourses about 'madness' functioned to establish stigma? I retrieve personal accounts from these hegemonic publications, establishing how the presence of paratexts and psychiatric 'authority' manipulate the receipt of such narratives. This will demonstrate how the historic silencing of 'madness' began.

Chapter three focuses on how a cross section of nineteenth-century fiction portrays 'madness', in order to explore the potential for fiction to offer 'madness' an accessible narrative platform. Initially, I examine literature as a continuation of psychiatric discourse, including Edgar Allan Poe's 'The Tell-Tale Heart'; Alfred Lord Tennyson's 'Maud'; Bram Stoker's *Dracula*; and Elizabeth Braddon's *Lady Audley's Secret*. As a point of comparison, I examine literary representations which go beyond psychiatric discourse to articulate 'madness', exploring Charlotte Perkins Gilman's *The Yellow Wallpaper*; Edgar Allan Poe's 'The System of Doctor Tarr and Professor Fether'; and texts which explore other selves and other worlds (Edgar Allan Poe's 'William Wilson'; and Lewis Carroll's *Alice's Adventures in Wonderland* and *Through the Looking-Glass*).

Chapter four examines the merits of visual art as a platform for 'madness' narratives, as it is divorced from many of the issues which are latent in language use. I explore the oeuvres of nineteenth- and early-twentieth-century artists Richard Dadd, Vincent Van Gogh, Louis Wain, Adolf Wölfli, August Klett, and Hyacinth Freiherr von Wieser. Despite the theoretical assumption that visual art is universal and accessible, the social reception of art, necessary for this communication to be heard and validated, proves that the practice is far removed from this hypothesis. The stereotype of the 'mad' artist is, in itself, an oxymoron: in the realm of social engagement, either the artistic identity of the individual is compromised and eventually disparaged, or 'madness' is obscured and censored.

Chapter five shows how the nineteenth-century model for (mis)understanding 'madness' is the foundation for our twenty-first-century discourse. This chapter examines narratives of 'madness' in popular culture, to understand how these discourses echo or challenge psychiatric representations of 'madness', and how a mainstream social audience is encouraged to feel about such depictions, including episodes *The Simpsons*, *House* and *Peep Show*, to explore how psychiatric discourse has shaped these narratives. This chapter also scrutinises the language employed by the media and other mainstream agencies in order to establish what these popular discourses reveal about entrenched societal prejudices and fear. This thesis addresses the question: can we truly ever speak of 'madness' without simultaneously silencing it?

INTRODUCTION

The Self Versus Psychiatry: The Politics of Narrating 'Madness'

An individual in the mental health system today has the same chance of 'recovery' as their nineteenth-century equivalent.[1] Since the nineteenth century, there has been an apparent acknowledgement of the stigma surrounding mental illness; the development of psychopharmacology; and a move from asylum culture towards 'community care'. However, despite this 'progress', I contend that psychiatric discourses of 'madness' and the prognosis for an experience of 'madness' have not changed or improved.[2]

Since the genesis of psychiatry, 'madness' has been depicted as requiring psychiatric management. In a twenty-first-century Western context, despite government and legal policies that champion deinstitutionalisation, current statistics suggest that those who experience 'madness' still need psychiatric intervention.[3] From 2012 to 2013, 'there were nearly 1.6 million people in contact with specialist mental health services', and 50,408 individuals were detained under the Mental Health Act.[4] 'Madness' is still clearly portrayed as belonging to the realm of psychiatry: this dynamic establishes psychiatry as the authority

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[1] David Healy, *The Creation of Psychopharmacology* (London: Harvard University Press, 2002), p. 12.

[2] My use of the term 'experience' is not in a phenomenological context, but more fitting to the *OED* definition of 'being consciously the subject of a state or condition, or of being consciously affected by an event'. *OED*, 'experience', <http://www.oed.com/view/Entry/66520?rskey=pXckwY&result=1&isAdvanced=false#eid> [accessed 15 June 2015].

[3] Britain's policy which focuses on community-based mental health and social care rather than hospitalisation and institutionalisation – referred to as the 'care in the community' policy – came into being in the 1980s. See Sir Roy Griffiths's 1988 report entitled 'Community Care: Agenda for Action'. This shift was enabled by a series of legal changes to 'patient' rights, such as 'the 1959 Mental Health Act [which] abolished the distinction between psychiatric and other hospitals and encouraged the development of community care' and 'the Mental Health Act 1983 [which] set out the rights of people admitted to mental hospitals, allowing them to appeal against committal'. See 'The Origins of Community Care', 13 October 1999, *BBC News* <http://news.bbc.co.uk/1/hi/health/229517.stm> [accessed 16 April 2016].

[4] Information taken from National Health Service Confederation, 'Key Facts and Trends in Mental Health' <http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/facts-trends-mental-health-2014.pdf> [accessed 2 October 2015].

on ‘madness’ – significantly usurping that authority from the individual experiencing ‘madness’. When someone engages with mental health services, a diagnostic label is attached to them, and with it, the enforcement of a particular social role. As anthropologist and psychologist James Davies observed, ‘as soon as you’re assigned a diagnosis […] you become a protagonist in a larger myth […] you have entered into a social contract in which you are now socially positioned as *dependant on psychiatric authority*’.[5] As I demonstrate throughout this thesis, contact with psychiatry acts to medicalise, dehumanise and ‘other’ ‘madness’. This means that the individual experience remains unspoken or unheeded; dominated and silenced by psychiatry, *the* hegemonic discourse on ‘madness’.

When I talk about the language of ‘madness’, I do so from three perspectives. I approach it as a researcher, examining it as both historical issue and twenty-first-century concern. Second, I understand it in a professional capacity, as someone who works in mental health, and who regularly witnesses the impact of stigma and discrimination. In this role, I am able to understand the parts both mainstream society and the mental health system inadvertently play in reinforcing the marginalisation of those labelled ‘mad’. Finally, as someone who has been on the receiving end both of stigma and of psychiatric intervention and ‘treatment’, I am able to appreciate the gravity of a psychiatric diagnosis. I am, however, in this third of three standpoints, only able to speak of my own account of ‘madness’, and my own experience of being ‘mad’ in a Western context.[6] Despite my educational privilege, there is no immunity from ‘madness’. Mental illness is a disorder of equal opportunity.

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[5] James Davies, *Cracked: Why Psychiatry is Doing More Harm Than Good* (London: Faber and Faber, 2013), p. 219. Italics added for emphasis.

[6] I am grouping together Western social attitudes towards ‘madness’ as, despite geographical diversity, all have been subjected to the same overarching psychiatric discourse. Clinical psychiatrist Michael Stone described how this discourse was homogenised across Europe: British psychiatric ‘developments’ were ‘occurring [elsewhere] on the continent’, with the likes of France, Germany and Britain all witnessing ‘the same […] movements’. Michael H. Stone, *Healing the Mind: A History of Psychiatry from Antiquity to the Present* (London: Pimlico, 1998), p. 104. My knowledge of what it means to be ‘mad’ in a Western context is also enhanced by my experience of working in the UK mental health system.

Current statistics state that one in four people will experience a mental health problem each year in the United Kingdom.[7] According to anthropologist Robin Dunbar, each individual has a 'social world' populated by approximately 150 people: this is 'the number of people that you know as persons and you know how they fit into your social world and they know how you fit into theirs'.[8] When these statistics are combined, it is fair to assume that over thirty-five people in the social network of the 'average' person experience some form of mental illness.[9] In theory, we are well placed to learn about 'madness' from this wealth of first-hand knowledge which surrounds us. However, despite having direct contact with those living through 'madness' – those who are *experts by experience* – Western society perpetually silences individual narratives in favour of psychiatric discourse.[10] But how did this trend begin: how did we learn to heed one account and disregard another? Who is the true authority on 'madness'? To whom should we be listening: the discourse *about* 'madness', or the discourse *of* it?

'Madness' is clearly a political and financial priority. From 2012 to 2013, investment in UK mental health services totalled over £6.5 billion, a number which has increased by 59% since 2001.[11] The UK government's Department of Health has invested vast amounts of money into the mental health system in an attempt to accommodate current – and growing –

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[7] Information taken from Mind, 'Mental Health Facts and Statistics' <http://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/> [accessed 16 April 2015].

[8] Robin Dunbar, quoted in Tom Geoghegan, 'What's the Ideal Number of Friends?', *BBC News Magazine*, 3 March 2009 <http://news.bbc.co.uk/1/hi/7920434.stm> [accessed 9 October 2015].

[9] Geoghegan, 'Number of Friends'

[10] When referring to 'psychiatric discourse', I am unable to ignore the spectre of the definite article entirely. In this thesis, the definite article has been omitted in this context as there are multiple psychiatric narratives which form hegemonic discourse, although there is an overarching, mainstream psychiatric narrative which excludes, for example, anti-psychiatric voices and 'patient' experiences. Any references to 'hegemony' refer to psychiatric hegemony unless otherwise specified. However, as indicated by the title of my thesis, I believe that lived experience needs to be understood as the authoritative discourse of 'madness', or at least be viewed as equal to or merged with psychiatric discourse in a way that does not serve to censor or disenfranchise. Information and knowledge should come from experts by experience, rather than experts by observation.

[11] Mental Health Strategies, '2011/12 National Survey of Investment', 3 August 2012 <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/140098/FinMap2012-NatReportAdult-0308212.pdf> [accessed 2 October 2015]. However, the impact of this financial investment is severely undermined by government austerity measures, such as cuts to support services, social services and the NHS, and tougher Work Capability Assessments.

demand. Despite this expenditure, the prognosis for 'madness' has not improved since the genesis of psychiatry: in the nineteenth-century asylum, 'recovery rates of up to 50 percent were reported. Such rates are comparable to those of psychiatric facilities today'.[12] As a society, we are clearly doing something wrong. More and more money is spent on mental health provisions, but the prognosis of 'madness' has not changed. Stigma still exists. Despite being increasingly likely to know experts by experience, we still rely on psychiatric discourse for (mis)information. Because of this, personal experiences of 'madness' more often than not remain unknown and unfamiliar.

The primary aim of this thesis is to identify how and why lived experiences of 'madness' are obscured and 'othered' in favour of psychiatric discourse. This silencing of the language *of* 'madness' is the catalyst for stigma. French philosopher Michel Foucault observed that 'language is the primary and ultimate structure of madness. It is the constituent form, since it is on language that all the cycles in which it reveals its nature rely'. [13] Society depends on language to communicate information: for the three out of four without personal experience of mental illness, the language surrounding it is their only point of reference for 'madness'. In the absence of a narrative which counters hegemonic discourse, 'the language of psychiatry […] shapes public discourse on mental health'.[14] This thesis demonstrates that there is both judgement and condemnation latent in psychiatric and social language about 'madness'. As anti-psychiatrist R. D. Laing asserted, 'the label [attached to an individual] is a social fact, and the social fact a political event [which] imposes definitions and consequences on the labelled person […] *he is invalidated as a human being*'.[15]

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[12] Healy, *Psychopharmacology*, p. 12.
[13] Michel Foucault, *History of Madness*, trans. by Jonathan Murphy and Jean Khalfa (London: Routledge, 1972), p. 237.
[14] Simon Cross, *Mediating Madness* (London: Palgrave Macmillan, 2010), p. 33.
[15] R. D. Laing, *The Politics of Experience and The Bird of Paradise* (Harmondsworth: Penguin, 1990), pp. 100-01. Although I refer to Laing as a part of the anti-psychiatry movement, this is something of an oversimplification. Laing himself dismissed the label, although his rejection of the medical model of mental illness in favour of an anthropological approach ran counter to orthodox psychiatric narratives. As with the

Stigma is a semantic issue. The term 'stigma', originating in Ancient Greece, initially referred to the physical and the visual, to 'bodily signs designed to expose something unusual and bad about the moral status of the signifier'.[16] However, the social concept of stigma has evolved. According to sociologist Erving Goffman, post-war use of the term evokes 'the disgrace itself rather than to the bodily evidence of it'.[17] As I will demonstrate, psychiatric language about 'madness' is loaded with an *assumption* of 'disgrace': that to be labelled 'mad' is to be simultaneously 'disgraced'. This language is not a neutral discourse. It signifies 'otherness', and thus it is fundamental to the genesis and maintenance of the social stigma surrounding mental illness.

The process of attaching and enforcing stigma is disconcertingly simple. The individual experiencing 'madness' is given a psychiatric diagnosis – for example, 'schizophrenia'. That label has social ramifications. To name but a few of these, it might denote the potential for violence, or an ill-informed assumption of a split personality: tropes which render the individual experience 'other'. Psychiatric discourse informs us that 'schizophrenia' is characterised by speech abnormalities – 'poverty of speech'[18], 'incoherent speech'[19], 'difficult[y] grasp[ing] meaning'[20] – failures in communication which depict lived experience of 'madness' as a 'closed' and inaccessible narrative.[21] As the individual narrative does not enter popular currency; the 'authority' of psychiatric discourse is reinforced. Any account which could contradict the assumptions of hegemony, or that could make 'madness' familiar, something relatable and thus other than 'other', is silenced. If the language we use to

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Outsider Art movement which I discuss further in chapter four, the anti-psychiatric movement was less of a conscious collective, and more an homogenised label attached in hindsight.

[16] Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity* (Harmondsworth: Penguin, 1990), p. 11.

[17] Goffman, *Stigma*, p. 11.

[18] Christopher Frith, 'Language and Communication in Schizophrenia', in *Communication and the Mentally Ill Patient*, ed. by Jenny France and Niki Muir (London: Jessica Kingsley Publishers, 1997), pp. 10-17 (p. 10).

[19] Richard Keefe and Philip D. Harvey, *Understanding Schizophrenia: A Guide to the New Research on Causes and Treatment* (New York: Simon and Schuster, 1994), p. 22.

[20] Philip Cowen, Paul Harrison and Tom Burns, *Shorter Oxford Textbook of Psychiatry* (Oxford: Oxford University Press, 2012), p. 256.

[21] I discuss these terms in more detail in chapter one.

describe and inform is flawed and tainted, but never challenged; if it is instead perpetually echoed, the cycle will never be broken.

Socially, we are aware of stigma but only as an abstract concept. We understand it as a *theory* but, as society has not yet meaningfully acknowledged lived experiences of 'madness', we do not comprehend it as a reality for those who contend with such discrimination on a daily basis. Western society has recognised stigma as an issue but has not identified clear, realistic solutions. This thesis explores how language functions as the foundation for stigma by establishing how the language of 'madness' has historically impacted on the individual narrative, from the birth of psychiatry and taxonomy in the nineteenth century, to our twenty-first-century context. I reveal the roles mainstream society has played in implicitly supporting limited and limiting psychiatric discourse, and I identify alternatives and solutions: ways in which 'madness' can be communicated without immediately evoking stigma and judgement. I investigate how 'madness' can be known without being 'othered'.

It is inevitable that, in a thesis concerned with the language of 'madness', my own use of terminology invites scrutiny. I have chosen to refer to an experience of mental illness as 'madness'. Historian Roy Porter described the term 'madness' as assuming 'all the solemnity of a clinical diagnosis, or [it could] be a street-corner insult: now a stigma, next an endearment [it] trade[s] upon the mysteries of liminality'.[22] Not only is 'madness' comprehensive – encompassing both neurosis and psychosis – there is something inherently fluid in the term which contrasts with the rigidity of psychiatric terminology. Rather than reductionist vocabulary such as 'schizophrenia' and 'bipolar', which corresponds to specific psychiatric classifications, the definition of 'madness' can range from 'imprudence', 'wild

[22] Roy Porter, *Madmen: A Social History of Madhouses, Mad-Doctors and Lunatics* (Oxon: The History Press, 2004), p. 32.

excitement or enthusiasm', 'anger', 'strange' and 'unusual', to 'infatuated'.[23]

In our Western context, we refer to numerous things as 'mad' without them automatically being 'other'. 'Madness' is 'often […] used as a rhetorical device'.[24] Retailers advertise 'mad' sales; we have 'mad' days at work; as an adjective, it can apply to anything from the traffic to the weather. We use the term 'mad' to describe enthusiasm and passion, such as 'football-mad' or 'shopping-mad'. Out of all available terms to discuss mental illness, 'madness' appears the least static, and thus has the potential to be the least 'other'. When I speak of 'madness' (as opposed to 'mental patient' or 'mentally ill'), the lack of clinical, diagnostic vocabulary does not immediately suggest an individual that has been pathologised.[25] There is potential for 'madness' to be self-managed, rather than instantly dismissed as belonging to the realm of – and submitting to – psychiatric forces, as '*madness* is a term that actively defies […] formal diagnostic categorisation'.[26] 'Madness' is not a passive term, and my use of it is also a nod to the activist 'resistance network' Mad Pride.[27] However, I have also used this word with the qualifier of quotation marks to expose the fragility and arbitrary nature of the 'sane'/'mad' binary opposition.[28] Similarly, at various points in this thesis, I refer to the 'mad' individual as a 'patient'. This is not intended to be reductionist: I am specifically signifying an individual in a psychiatric context which renders them a 'patient', subservient to psychiatric 'authority'. Quotation marks highlight the problematic power dynamics latent in the 'patient'/psychiatrist relationship.

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[23] *OED*, 'madness' <http://www.oed.com/view/Entry/112066?redirectedFrom=madness&> [accessed 2 October 2015].
[24] Charley Baker and others, *Madness in Post-1945 British and American Fiction* (Hampshire: Palgrave Macmillan, 2010), p. 4.
[25] In this respect, my use of less sanitised and rigid terminology contrasts with the suggestion given by Time to Change, a UK campaign dedicated to eradicating stigma. Time to Change advise that instead of 'mad', we employ the term 'a person with a mental health problem', but I feel that such phrasing is both clunky and indicative of an individual in a psychiatric – and thus medicalised and 'othered' – context. See Time to Change, 'Mind your Language!' <http://www.time-to-change.org.uk/news-media/media-advisory-service/help-journalists/mind-your-language> [accessed 2 October 2015].
[26] Baker, *Madness*, p. 4. Emphasis in original.
[27] For more information, see Mad Pride <http://madpride.org.uk/index.php> [accessed 16 June 2016].
[28] I discuss this problematic binary further in chapter one.

The phrase ‘madness narrative’ refers to any account of an individual experience of ‘madness’. Throughout this thesis, I examine ‘madness’ narratives in various contexts, from those salvaged from psychiatric textbooks, to literary narratives, to representations in visual art. ‘Madness’ narratives should be understood as distinct from psychiatric discourse: I am referring to an attempt to articulate ‘madness’ as a *lived* experience – a narrative *of* ‘madness’, rather than *about* it.

The Language of ‘Madness’: A Theoretical Approach

The focus of my first chapter is to establish how and when the language available to discuss ‘madness’ became so problematic, and how this impacts on the individual’s experience. I approach psychiatric discourse about ‘madness’ using linguist Ferdinand de Saussure’s hypothesis of signification. Psychiatric discourse is the only semantic framework employed to discuss ‘madness’ in a mainstream social context. I use Saussure’s process of signification and the concept of the sign as a means of deconstructing psychiatric labels.[29] When an individual receives a psychiatric diagnosis, a signifier (the label) is projected onto the signified (the individual). Thus, the individual is burdened with the meaning of this signifier, often permanently. I explore both psychiatric and social baggage attached to taxonomy, in order to identify the genesis of stigma. If we understand the process which created stigma, can this process be halted or even reversed?

Chapter one continues by investigating another language problem: the language of the ‘patient’. This discourse has been thoroughly medicalised, with the symptom pool for ‘madness’ relying heavily on the ‘mad’ individual’s relationship with semantics. How can one articulate one’s personal experiences when one’s speech and narrative have already been dismissed as ‘other’? I establish the role these semantic politics play in verifying the

[29] My use of the term ‘deconstruct’ throughout is not Derridean, but refers to the process of dismantling; taking language and the associated politics apart to understand how they function to establish and enforce stigma.

'patient'/psychiatrist relationship. Using psychoanalyst Jacques Lacan's theory of the *nom du père*, I investigate the assumption that 'madness' is a rejection of conventional language. I question who is to blame when language fails: Sigmund Freud described the disconnect between 'madness' and language as a 'failure of translation'.[30] Is this due to the 'patient' consciously refusing to conform to the *nom du père*? Is it the fault of the psychiatrist, for misunderstanding the signifiers of the 'patient', and recognising only symptoms and anomalies? Or does this 'failure' reveal an underlying flaw in the language system, which prevents lived experience of 'madness' from being acknowledged by a social audience?

Of central importance is the significant role narratives play in allowing for social engagement and validation: essential for the self after a traumatic experience of illness. Chapter one deconstructs the narrative process in order to investigate where 'madness' narratives fail. The process begins with the individual: a narrative is an articulation of the experiences of the self. The narrative is then communicated through a medium; most frequently it is constructed using language. Finally, the narrative needs to be delivered to – and *validated* by – a social audience.

When it comes to speaking *of* 'madness', the primary obstacle is a semantic conflict between authenticity and accessibility.[31] The only current mainstream language about 'madness' is the discourse of psychiatry: this is the socially familiar, and thus available, vocabulary. A personal narrative formulated in these terms is one which fails to communicate an *authentic* sense of what 'madness' is – this hegemonic discourse speaks of psychiatry's experience of 'madness', but not lived experience. Such a narrative may be socially accessible, but the self is jeopardised: rather than offering a radical counter-narrative, an account which is constructed using psychiatric discourse will serve only to reinstate psychiatry's 'authority'.

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[30] Sigmund Freud, *The Complete Letters of Sigmund Freud to Wilhelm Fliess 1887-1904*, trans. and ed. by Jeffrey Moussaieff Masson (Cambridge: Belknap Press, 1986), p. 208.

[31] I unpick the notion of 'authenticity' further in both chapter one and chapter two.

The alternative is to communicate 'madness' through an unconventional medium, and by means of unorthodox language, in order to accommodate and articulate lived experiences. Such narratives are able to communicate *authentic* 'madness' – an experience not limited to, distorted, or censored by psychiatric language. However, as these semantics or narrative models deviate from familiar modes of communication, the final part of the process – delivery to a social audience – is forfeited: these narratives are not validated by their social recipients.

The process of communicating 'madness' is obstructed by a conflict between expectation and experience. Narrative theorists Elinor Ochs and Lisa Capps observed that 'the struggle to reconcile expectation with experience is particularly salient in the narratives of sufferers of mental and physical illness'.[32] Our response to a narrative is heavily influenced by the presence of paratexts: both literal (such as an editor's note, a preface, or an introduction) and metaphorical (such as the expectations and assumptions one may harbour when a certain text is approached). Chapter one establishes the impact this framing has on the reception of a lived account of 'madness': is it, in fact, this excess material which obstructs the dissemination of a 'madness' narrative? Can an awareness of these other voices allow us, as a society, to adapt our reading process to deconstruct and disregard damaging paratexts?

'Plundered, Organised and Published': Constructing the Self under the Psychiatrist's Gaze[33]

The theoretical grounding of chapter one establishes the semantic and narrative obstacles that must be negotiated in order to speak of 'madness'. In chapter two, I examine the reality of these politics. This chapter covers a variety of 'madness' narratives salvaged from psychiatric

[32] Elinor Ochs and Lisa Capps, 'Narrating the Self', *Annual Review of Anthropology*, 25 (1996), 19-43 (p. 29).
[33] Emil Kraepelin, *Dementia Praecox and Paraphrenia*, trans. by Mary Barclay (Chicago: Chicago Medical Book Company, 1916), p. 12.

case studies and textbooks: I refer to the individual narrative within these texts as a 'case study narrative'. My focus is nineteenth- and early twentieth-century publications, for example those of influential psychiatrists Emil Kraepelin, Eugen Bleuler and Sigmund Freud. Such texts have been essential to the development of psychiatry as a discipline, but how have these discourses about 'madness' functioned to establish stigma? I investigate how the language about 'madness' became so inextricable from the stigma which now animates it; which gives 'madness' meaning in a mainstream social context; and which grants psychiatric vocabulary a semiological life of its own.

Hidden within the paratexts of psychiatric publications – such as Kraepelin's *Lectures on Clinical Psychiatry* (1904) and *Dementia Praecox and Paraphrenia* (1916); Bleuler's *Textbook of Psychiatry* (1924); and Freud's *Studies on Hysteria* (1895), *Case Histories I* (based on cases published in 1905 and 1909), *Case Histories II* (material originally published between 1909-20), and *A Case of Hysteria* (1905) – 'madness' narratives are employed as proof of an anomaly or symptom. The presence of the 'mad' voice is permitted only to reflect 'otherness', to *be* 'other'. However, I retrieve personal accounts from these hegemonic publications, establishing how the presence of paratexts and psychiatric 'authority' manipulate the receipt of such narratives. This will demonstrate how the historic silencing of 'madness' began. My interest lies in the language choices employed by the individual to discuss their experience of 'madness': how is the self configured and communicated after a disorientating and devastating experience of illness and, perhaps, incarceration?[34] What relationship does this semantic account have with hegemonic discourse, and how might it be received in a social context?

[34] My use of the term 'incarceration' here and throughout refers both to the physical act of confinement and to the inevitable political disenfranchisement which occurs when a 'patient' is detained. As Goffman argued, institutionalisation 'disrupt[s] or defile[s]' the autonomy of the 'patient'. See Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New Jersey: Transaction Publishers, 2007), p. 43.

By deconstructing the paratexts which frame case study narratives, I identify how these narrative layers serve further to distort the 'mad' voice, and establish and reinforce the dynamics of the 'patient'/psychiatrist relationship. As I demonstrate in chapter one, 'madness' narratives are a battleground for experience versus expectation. The narrative framing which features in my chosen psychiatric texts functions to shape the expectations of the reader. This encourages a social audience to rely on psychiatric 'authority' before the individual account – the experience – is presented. I examine how society is urged to respond to lived experience of 'madness'. I also expose how the role of 'authority' assumed by the psychiatric presence overrides the 'authority' of the individual.

The rest of chapter two is organised according to different relationships with language. First of all, I examine case study narratives which echo or employ psychiatric discourse as a means of communicating an experience of 'madness'. Although using such conventional semantics to articulate 'madness' offers the promise of social validation, the limited and limiting nature of this language has an inevitable and damaging impact on social and personal conceptions of identity. To accept and internalise psychiatric discourse is to submit to the role of 'patient': a marginalised position, subject to psychiatric 'authority'. However, according to philosopher Georg Hegel, this is a necessary part of 'recovery': 'cure must be sought in the re-externalization (rebirth) of the self into relations with others through a path back to language'.[35] When hegemonic discourse is adopted by the 'patient', does the promise of 'cure' outweigh the risk of reducing the self to a label?

As a point of comparison, I examine what happens when case study narratives refuse to conform to discourse imposed by the psychiatric presence. This chapter explores alternative semantic frameworks employed to discuss 'madness'. These range from a

[35] Daniel Berthold, 'Talking Cures: A Lacanian Reading of Hegel and Kierkegaard on Language and Madness', *Philosophy, Psychiatry, and Psychology*, 4 (2009), 299-311(p. 306). Wherever possible, I have gone to the original of all sources used. However, on occasion, despite thorough research, the original has not always been accessible.

marriage of ‘madness’ and spirituality, to an overt rejection of the illness model, to narratives which transcend orthodox language. I focus on where these verbalised accounts contrast with conventional models for talking about ‘madness’, primarily, the ways in which the self is articulated, and how the psychiatric presence encourages the reader to respond to such narratives. These accounts are, potentially, radical counter-narratives which threaten to undermine psychiatric (mis)understandings of ‘madness’; they represent the possibility that ‘madness’ can evoke empathy and become familiar, divorced from the ‘otherness’ latent in psychiatric vocabulary. How has the psychiatric presence prevented such narratives from entering popular currency? If we understand how this process began, might we find ways to reverse it, allowing personal experience of ‘madness’ to become *known*?

Finally, chapter two investigates case study narratives which are reluctant – or unable – to verbalise an experience of ‘madness’. Here, the significance of silence is considered: to be silent can be to bid for power, to submit and/or to refuse to expose the self to psychiatric forces. A silent ‘patient’ represents a blank canvas, onto which the psychiatrist can project assumptions, labels and theories. However, silence can also represent a refusal to engage with the power dynamics of the ‘patient’/psychiatrist relationship: if ‘madness’ is manifest in speech anomalies, an *absence* of speech denies psychiatry of its principal medium. Can silence be used as a narrative model, or is it merely a last resort to protect the self against psychiatric intervention?

‘An Illusion of Exteriority’: Rereading Literary ‘Madness’[36]

Chapter two, then, serves to establish the narrative and semantic politics which prevent case study narratives from being accessed by a receptive audience. The psychiatric presence in these texts influences the reader, shaping expectations which serve to undermine the

[36] Chris Wiesenthal, *Figuring Madness in Nineteenth-Century Fiction* (Hampshire: Macmillan, 1997), p. 17.

perceived *worth* of individual experience. However, fiction, by its very nature, offers a less regulated platform: divorced from an explicitly psychiatric context, there is potential for fiction to represent ‘madness’ without simultaneously ‘othering’ it. Chapter three focuses on how a cross section of nineteenth-century fiction portrays ‘madness’. Compared to case study narratives, fiction offers a direct conduit between reader and text: there is no explicit psychiatric presence acting as intermediary. As literature occupies a unique space, both influencing and influenced by social discourses, is there potential for fiction to offer ‘madness’ an accessible narrative platform?

In order to forge a comparison between fictional accounts of ‘madness’ and case study narratives, chapter three is structured according to the relationship such texts have with language. Initially, I examine literature as a continuation of psychiatric discourse. I explore texts which, like hegemonic discourse, employ tropes of ‘otherness’ to articulate ‘madness’, and those which overtly rely on psychiatric terminology. My analysis begins with Edgar Allan Poe’s short story, ‘The Tell-Tale Heart’, through which ‘madness’ is, on the surface, at least, reduced to a Gothic subplot: an unreliable narrator and a violent, 2D villain. Alfred Lord Tennyson’s poem ‘Maud’ also propagates psychiatric myths of ‘madness’, representing ‘madness’ as the opposite of reason and borrowing from psychiatric discourse to describe ‘madness’. Similarly, Bram Stoker’s Gothic novel *Dracula* reflects hegemonic discourse, by portraying ‘madness’ in relation to governing psychiatric forces. Finally, Mary Elizabeth Braddon’s Sensation novel *Lady Audley’s Secret* evokes contemporary narratives of hereditary ‘madness’ and a phrenological merging of ‘madness’ and visual stereotypes: the text also represents a ‘mad’ protagonist who uses psychiatric terminology to construct her identity. Do these textual representations merely function to support and affirm the power of hegemonic narratives? Or, by exposing the damaging and limiting nature of psychiatric

discourse, can we interpret these texts as counter-narratives? How have these authors encouraged their readers to respond to, and connect with, the 'madness' they portray?

As a point of comparison, I examine literary representations which go beyond psychiatric discourse to articulate 'madness'. I explore Charlotte Perkins Gilman's short story *The Yellow Wallpaper*, which merges 'madness' and intense creativity, and which depicts a 'psychotic' break from 'reality' as liberation from a claustrophobic, patriarchal environment. I also analyse another short story by Edgar Allan Poe – 'The System of Doctor Tarr and Professor Fether' – which, in contrast to 'The Tell-Tale Heart', destabilises the binary oppositions of 'mad'/'sane', and 'patient'/psychiatrist. Finally, I examine texts which explore other selves and other worlds: Edgar Allan Poe's 'William Wilson'; and Lewis Carroll's *Alice's Adventures in Wonderland* and *Through the Looking-Glass*. Do these literary examples allow such 'alien' states – deviations from conventional understandings of the self and of 'reality' which characterise 'madness' – to become familiar, something to which the reader can relate, and thus empathise with?

From the 'Meaningless' to the Mythologised: 'Madness' Narratives and Art[37]

I have established the politics and problems latent in semantic accounts of 'madness': a verbalisation of 'madness' is either couched in psychiatric terms, and is thus limited and limiting, or it is formulated using unconventional language which prevents such narratives from being accessed and validated in a social context. In order to establish potential alternatives, chapter four examines the merits of visual art as a platform for 'madness' narratives, as it is divorced from many of the issues which are latent in language use. In the interests of examining the accessibility and universality of art as a narrative model, my chosen artists vary from the canonical to the less familiar: my only criterion is that the

[37] Hans Prinzhorn, *The Art of Insanity* (Chicago: Solar Books, 2011), p. 64.

individual has experienced – or has been told they experience – a form of ‘madness’ over the course of their lives. I explore the oeuvres of nineteenth- and early-twentieth-century artists Richard Dadd, Vincent Van Gogh, Louis Wain, Adolf Wölfli, August Klett (given the pseudonym ‘August Klotz’ by psychiatrist and art historian Hans Prinzhorn) and Hyacinth Freiherr von Wieser (given the pseudonym ‘Heinrich Welz’, again by Prinzhorn). All of these artists had direct contact with psychiatric forces, with diagnoses ranging from ‘schizophrenia’ to ‘generalised delirium’. Despite these diagnostic variables, the work of my chosen artists is used as a narrative platform to communicate a personal experience of ‘madness’, and so can be used to illuminate the tumultuous relationship between the ‘mad’ self, ‘reality’ and mainstream society.

Although, in theory, art is a medium detached from the stigma of language, it is subject to its own politics. Chapter four establishes the values and expectations of the mainstream art world in the nineteenth century, exploring orthodox assumptions of what art is in order to investigate the potential for it to accommodate an experience of ‘madness’. For example, the nineteenth-century trend for imitative art – images which *re*present ‘reality’ – is an unsuitable vehicle for a ‘madness’ narrative, as ‘madness’ is depicted as a break from shared notions of ‘reality’. I consider the viability of other genres – particularly the Outsider Art movement – to deliver an *authentic* ‘madness’ narrative to mainstream society.

This chapter exposes as a paradox the cliché of the ‘mad’ artist. On the one hand, there is the indisputable ‘madness’ of August Klett. The inescapable psychiatric context of his work ensures that his oeuvre is allowed only to reflect its ‘otherness’, interpreted as symptomatic of his ‘madness’, rather than as *art*. By contrast, the work of Vincent Van Gogh is indisputably perceived as Art, although Van Gogh’s identity as a mainstream artist has prevented his work from being received as a ‘madness’ narrative. Despite his art explicitly acknowledging his ‘mad’ identity – from self-portraits which feature his infamous act of self-

mutilation, to painting fellow 'patients' and his attending psychiatrist – I shall demonstrate how Van Gogh's 'madness' has been thoroughly deemphasised and silenced.

Despite the theoretical assumption that visual art is the only medium of 'complete and unhindered communication', the social reception of art, necessary for this communication to be heard and validated, proves that the practice is far removed from this hypothesis.[38] The stereotype of the 'mad' artist is, in itself, an oxymoron: in the realm of social engagement, either the artistic identity of the individual is compromised and eventually disparaged, or 'madness' is obscured and censored.

The Psychiatric, The Political and The Personal: How We Talk about 'Madness' Today

Where chapter one functions to establish the problems latent in verbalising 'madness'; chapters two and three explore the reality of these issues by examining how semantic politics impact on the narration of individual experiences; and chapter four examines the merits of possible alternatives. Chapter five demonstrates that, although my primary focus has been on nineteenth-century 'madness' narratives, this thesis is not intended to be entirely historical. Instead, I show how the nineteenth-century model for (mis)understanding 'madness' is the foundation for our twenty-first-century discourse. Despite the development of the *Diagnostic and Statistical Manual of Mental Disorders* – with its ever-expanding vocabulary to talk *about* 'madness' – alongside a move towards a 'scientific', drug-based paradigm of care and the 'care in the community' initiative, we are no closer to understanding 'madness', of learning from it, of accepting it, of empathising, or of truly helping those who desperately require support.[39]

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[38] John Dewey, *Art as Experience* (New York: Perigee, 2005), p. 109.

[39] For the sake of space, any further mention of the *Diagnostic and Statistical Manual of Mental Disorders* will use the well-established abbreviated title of *DSM*. In brief, the *DSM* is the standard classification for mental disorders used by medical professionals. The first edition of the *DSM* was published in 1952, coinciding with the development of first generation psychotropic medication: this was clearly a time during which the landscape of psychiatry was – on the surface – drastically changing. This edition listed a modest 106 mental disorders, and

Chapter five, then, examines narratives of 'madness' in popular culture, to understand how these discourses echo or challenge psychiatric representations of 'madness', and how a mainstream social audience is encouraged to feel about such depictions. I analyse episodes of American animated sitcom *The Simpsons,* American medical drama *House* and British cult comedy *Peep Show*, to explore how psychiatric discourse has shaped these narratives. These examples of popular culture have been chosen for their accessibility and wide audience: in a societal context, they function as readily available sources of information. Additionally, this chapter surveys other mainstream, twenty-first-century conversations about 'madness'. By scrutinising the language employed by the media and other mainstream agencies (such as the 2013 controversy over Asda's and Tesco's 'mental' Hallowe'en costumes), I establish what these popular discourses reveal about entrenched societal prejudices and fear. Primarily, I focus on the concept of institutionalisation – a continuous theme, despite the deinstitutionalisation championed by the 'care in the community' policy. I consider how this social fear of the 'free' 'mad' individual demonstrates both the continued reliance on nineteenth-century discourses of 'madness', and of a deep-seated social anxiety of the 'mad' individual who is not policed or contained by psychiatric forces.

As this thesis draws to a close, I discuss current problems and potential solutions. Representations of 'madness' fall into a distinct binary: on the one hand, there is an evident *fear* of the 'lunatic at large' – the 'mad' individual who is not 'managed' by psychiatry – on the other, there is the submissive 'mad' 'patient', who is 'othered' but contained by a psychiatric context. But what about those who occupy the liminal space between such

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would seem to have little in common with the most recent incarnation, the *DSM-V* – comprised of nearly 950 pages. The growth of medication culture, fuelled by the rise of biological theories surrounding mental illness, runs parallel to, and is driven by, the creation of the *DSM*. In the UK, there is also the *International Classification of Diseases* (*ICD*). However, James Davies reported that the *DSM* is often used over the *ICD*: 'in countries like Britain where the *ICD* is used along with the *DSM*, many mental health researchers and professionals often prefer the *DSM*. In fact, the National Institute for Clinical Excellence (the body that sets the clinical guidelines for the NHS) now recommends the use of the *DSM* over the *ICD* for disorders'. See Davies, *Cracked*, p. 19.

extremes? Those who fall in-between the twin pillars of mainstream depictions of 'madness' are not consistently or meaningfully represented in popular culture, which portrays 'madness' as a dichotomy which can only be sanitised by, and controlled with, psychiatric intervention. As a result, lived experience of the vast majority of those labelled 'mad' does not enter popular currency, and is thus perpetually silenced.

Since the birth of psychiatry and development of medical taxonomy in the nineteenth century, the prognosis of 'madness' remains unchanged: labelled with neo-Kraepelinian diagnostic categories; treated on the basis of theory rather than science; spoken of only in terms of 'otherness'; those diagnosed as 'mad' experience the same disenfranchisement and stigma as their nineteenth-century equivalents.[40] In the absence of the literal asylum, we have created a metaphorical one: a system of 'care' in the community, comprised of constant reminders of illness and 'otherness' – a daily regime of psychotropic medication, and regular contact with mental health services, in addition to waging a constant battle against stigma and discrimination.[41] Despite campaigns to eradicate stigma, the conversations *about* 'madness' remain static: while we continue to disregard lived experience, we will never be able to challenge the entrenched hegemonic discourse.

At the very least, this thesis is intended to encourage my reader to be *aware* of how language enforces stigma, to question their own use of language, and to challenge the language choices of those around them. I want my reader to be mindful that mainstream accounts of 'madness' are from those who *medicalise* and *medicate*. The current hegemony is

[40] Author and journalist Will Self discussed the reliance on theory rather than science in his short film, *Will Self's Street Drugs*. Self talks about the psychotropic drugs he had discovered on the streets outside his house as indicative of the growing number of individuals experiencing mental illness made homeless under the 'care in the community' initiative. When researching a recent find of Buccastem, Self observed: 'it's thought – *thought* – to block dopamine receptors […] there's an entire industry that is making vast profits off these *thoughts*. It's essentially a creative industry'. See *Will Self's Street Drugs* <https://www.youtube.com/watch?v=xvZuRSmmC3A> [accessed 2 July 2015]. Italics added for emphasis.

[41] A Time to Change survey revealed that 'almost nine out of ten people with mental health problems (87%) reported the negative impact of stigma and discrimination on their lives'. Information taken from Time to Change, 'Mental Health and Stigma' <http://www.time-to-change.org.uk/what-are-mental-health-problems/stigma-discrimination> [accessed 9 September 2015].

excluding, disenfranchising and ‘othering’ those who have lived through ‘madness’. We have the privilege of a voice, and the freedom to employ language, to speak and to be heard. But are we using this privilege to silence others?

CHAPTER ONE

The Language of 'Madness': A Theoretical Approach

In our everyday discourse, the power language wields is often overlooked. Saussure argued that 'in the lives of individuals and of societies, language is a factor of greater importance than any other'.[1] Language is a primary component in our social interaction: it is a tool used to describe, to explain, to create and maintain connections with those around us. We rely on language to externalise our internal narratives, to voice our thoughts, and to engage with others. The ability to communicate is an essential part of entering collective discourse, of being a vocal, active entity on the social landscape. Our identity is dictated by how we correspond or connect with our social context: our employment status, our family history, the relationships we establish. Our sense of self – despite seeming like a personal and intimate concept – is a profoundly public affair, determined by our ability to interact with and conform to the cultural networks in which we find ourselves.

British essayist Erich Heller observed that 'man has been given language […] so that he can say what he has chosen not to be silent about'.[2] This oversimplification of our relationship with language reinforces the idea that the ability to communicate is the 'norm'. It is assumed that language use is inextricable from the human condition: that, by virtue of having the physical mechanisms of speech (such as vocal chords), we have the privilege of communicating and being heard. Hegel asserted that 'to be a human self is to be a linguistic self': thus, to be silent – a non-linguistic self – is to be less than human.[3] The belief that being a 'linguistic self' is an intrinsic part of the human experience leaves little space on the social

[1] Ferdinand de Saussure, *Course in General Linguistics*, trans. by Roy Harris (London: Duckworth, 1983), p. 7.
[2] Erich Heller, 'Observations on Psychoanalysis and Modern Literature', in *Literature and Psychoanalysis*, ed. by Edith Kurzweil and William Phillips (New York: Columbia University Press, 1983), pp. 72-84 (p. 78).
[3] Berthold, 'Talking Cures', p. 306. Such an argument is, of course, ethically dubious.

landscape for the individual who is *silent* or *silenced*. Communication is 'bound up with […] structures of power and privilege', and the 'patient'/psychiatrist dynamic 'brings into particularly sharp focus the inequalities in power', as revealed by and sustained by the politics of language.[4]

The historic silencing of those labelled 'mad' is – paradoxically – inextricable from language. As social beings, we employ language to identify those we consider 'other', and rely on semantics to communicate that perceived difference to those around us: this enforces an 'us' versus 'them' binary, and allows us socially to marginalise those we brand 'other'. Goffman described stigma as 'the situation of the individual who is disqualified from full social acceptance'.[5] The individual who is categorised as 'mad' and burdened with the stigma evoked by that label is both condemned and censored by language; disqualified from becoming part of the self-same dialogue which denounces them. We have prevented 'madness' from answering back: we use our language to deny 'madness' the same privilege of voice.

This chapter will demonstrate that, when it comes to speaking *of* and *about* 'madness', language becomes both obstacle and tool: it has the 'power to harm as well as to heal'.[6] Foucault observed that 'language is the primary and ultimate structure of madness. It is the constituent form, since it is on language that all the cycles in which it reveals its nature rely'.[7] Society relies on language to absorb and communicate information: unless we have personal experience of 'madness', the language surrounding mental illness is our only point of reference for what 'madness' *is*, and what it *means*. From the birth of psychiatry in the nineteenth century to the development of the *DSM*, we have been granted language to talk about 'madness'. Psychiatrists have constructed a semantic framework to demarcate and

[4] Paul Crawford and others, *Communicating Care: The Language of Nursing* (Cheltenham: Stanley Thornes, 1998), p. 108.
[5] Goffman, *Stigma*, p. 9.
[6] Crawford, *Communicating Care*, p. 1.
[7] Foucault, *History of Madness*, p. 237.

diagnose ‘madness’. This language has evolved from a crude attempt to distinguish ‘idiocy’ from ‘insanity’ (as featured in an 1840 United States census), to the latest edition of the *DSM*: a hefty 947 pages.[8] However, when faced with the vast diversity of human experience, is it appropriate or even possible to reduce individual suffering to a homogenous ‘clinical entity’, regardless of how broad the psychiatric vocabulary is?[9] Despite attempting to approach ‘madness’ as a medical, biological phenomenon, psychiatric discourse ‘does not so much *define* as *denounce*’.[10]

Initially, this chapter investigates the language available to talk *about* ‘madness’. Psychiatric terminology provides the only mainstream point of reference for ‘madness’: problematically, we rely on clinical lexis to discuss distinctly subjective, personal experiences. I approach the development and employment of taxonomy through a Saussurean lens, using the process of signification and the concept of the sign to deconstruct the psychiatric labelling process. Applying a psychiatric category is the enforcement of signification: it apparently binds a signifier (a label) with the signified (the individual experience). However, the signifier becomes a *brand* – freighted with the social stigma attached to that term – which encompasses the individual, rather than just referring to the individual’s experience. We speak of *the ‘schizophrenic’*, not a fleeting, transient ‘schizophrenic’ episode: as observed by Laing, ‘once a “schizophrenic” there is a tendency to be regarded as always a “schizophrenic”’.[11] Psychiatric discourse reduces ‘madness’ to a signifier which medicalises and objectifies. Human experience – along with the possibility of understanding and empathy – is alien to the governing language *about* ‘madness’. As Laing asked, ‘how can one demonstrate the general human relevance and significance of the

[8] For more information on the 1840 US census, see Kim E. Nielson, *A Disability History of the United States* (Boston: Beacon Press, 2012).
[9] R.D. Laing, *The Divided Self* (Harmondsworth: Penguin, 1965), p. 18.
[10] Foucault, *History of Madness*, p. 163. Emphasis in original.
[11] Laing, *Politics*, p. 101.

patient's condition if the words one has to use are specifically designed to isolate and circumscribe the meaning of the patient's life to a particular clinical entity?'[12]

I explore the disconnect between this language (a psychiatric label) and its subject (a lived experience of 'madness') in order to identify the origins of stigma. Time to Change conducted a survey in 2008 which revealed that 'almost nine out of ten people with mental health problems (87%) reported the negative impact of stigma and discrimination on their lives'.[13] Academic and writer Simon Cross rightly observed that 'the language of psychiatry […] shapes public discourse on mental health'.[14] Despite the clinical genesis of such language, it comes with social baggage, with stigma. It is not an objective discourse. Psychiatric terms imply a 'marked deviation from conventional or normal ways of acting, or thinking, or feeling [...] to make it appear that there must be something lacking in the constitutional makeup of the individual'.[15] Significantly, this results in the individual being 'disqualified from full social acceptance', stigmatised in order to disenfranchise and maintain the silence of those labelled 'mad'.[16]

Rather than exclusively denoting a medical entity, psychiatric vocabulary overlaps with the sphere of moral judgement. Terms such as 'schizophrenic' and 'psychotic' do not just signify illness: they refer to a social role, a marginalised identity, or a permanent state of 'otherness'. Laing elaborated:

> The label is a social fact, and the social fact a political event [which] imposes definitions and consequences on the labelled person. It is a social prescription that rationalizes a set of social actions whereby the labelled person is annexed by others […] The "committed" person is labelled as patient, and […] is degraded from full existential and legal status as human agent and responsible person, no longer in possession of his own definition of himself […] the space he occupies is no longer of his own choosing […] *he is invalidated as a human being.*[17]

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[12] Laing, *Divided*, p. 18.
[13] Time to Change, 'Stigma'.
[14] Cross, *Mediating Madness*, p. 33.
[15] Robert E. L. Faris, 'Cultural Isolation and the Schizophrenic Personality', *American Journal of Sociology*, 2 (1934), 155-64, (p. 156).
[16] Goffman, *Stigma*, p. 9.
[17] Laing, *Politics*, pp. 100-01. Italics added for emphasis.

James Davies argued that 'as soon as you're assigned a diagnosis […] you become a protagonist in a larger myth […] in which you are now socially positioned as dependent on psychiatric authority'.[18] In later chapters of my thesis, I explore the psychiatric assumption that 'madness' equates to 'otherness', considering how this trope has become firmly entrenched in popular discourse and culture. This present chapter investigates *how* psychiatric discourse has come to imply *so much more* than a state of illness. Taxonomy occupies a paradoxically objective and subjective space: 'a fear formulated in medical terms but animated, basically, by a moral myth'.[19] How is it that a word such as 'schizophrenia' can – allegedly – denote a chemical deficiency in the brain, while simultaneously imposing moral judgement?[20] How can this language refer to a supposed medical anomaly and yet simultaneously 'invalidate' one's humanity?

The silence of 'madness' has a complex history: it is a phenomenon tightly bound to the formulation and employment of psychiatric taxonomy. I establish how language *about* 'madness' misrepresents, distorts and 'others' lived experience, rendering it an 'imperfectly known' and unfamiliar state.[21] However, this is not the only obstacle posed by the tumultuous relationship between 'madness' and language. Language use acquires a new dimension of significance in the 'patient'/psychiatrist relationship. Unlike the realm of somatic medicine, characterised by a physical process (such as an x-ray to demonstrate the presence of a

[18] Davies, *Cracked*, p. 219.
[19] Michel Foucault, *Madness and Civilization*, trans. by Richard Howard (New York: Random House, 1988), p. 202.
[20] This reference to brain chemicals is rooted in the popular hypothesis that 'schizophrenia' is caused by an abundance of dopamine, and 'depression' is the result of low serotonin levels. However, psychiatrist Joanna Moncrieff stated that 'it is important that everyone knows how little evidence there is to support [these theories]' (see Joanna Moncrieff, 'The Chemical Imbalance Theory of Depression' <http://joannamoncrieff.com/2014/05/01/the-chemical-imbalance-theory-of-depression-still-promoted-but-still-unfounded/> [accessed 9 July 2015].
[21] Foucault, *History of Madness*, p. 79.

fracture), psychiatry's primary currency to 'prove' the presence of an anomaly is the narrative of the 'patient'. As Lacan observed, there is 'only a single medium: the patient's speech'.[22]

However, instead of this reliance on the narrative of the 'patient' bestowing personal accounts of 'madness' with mythological importance, the opposite has happened. The language of the 'patient' has been thoroughly medicalised, to the extent that constellations of symptoms associated with 'madness' centre on the 'mad' individual's relationship with language. I explore this medicalisation of language use: from Kraepelin's claim that 'madness' is characterised by 'peculiar, distorted turns of speech – senseless playing with syllables and words' to increasingly clinical, twenty-first-century terms such as 'poverty of speech'.[23] This assumption that the 'mad' individual's discourse is characterised by 'speech pathology or disturbed communication', serves to invalidate 'madness' narratives.[24] If psychiatry declares the 'patient' narrative 'incoherent', 'incomprehensible' – what anthropologist Anne M. Lovell termed a 'closed' text – then lived experience of 'madness' is not granted any importance other than providing psychiatry with the means for a diagnosis.[25]

Thus far, a dual language problem has been identified: first, the language which surrounds 'madness' is limited and limiting; second, this language imposes social 'otherness', often permanently. Were a counter-narrative to exist, articulating an individual experience of 'madness' but in accessible, human terms (rather than in clinical, psychiatric vocabulary), there is potential for this 'otherness' to be diminished, and for lived experience to enter popular currency. However, the possibility of such a counter-narrative being heard becomes increasingly remote with the medicalisation of language use. Narratives are depicted as symptoms, as 'empty speech', rather than a vitally important bid to be heard, and for the self

[22] Jacques Lacan, *Écrits: A Selection*, trans. by Alan Sheridan (London: Routledge, 2001), p. 44.
[23] Emil Kraepelin, *Lectures on Clinical Psychiatry*, trans. by Mary Barclay, ed. by Thomas Johnstone (New York: William Wood, 1904), p. 24.
[24] Roy H. Wolcott, 'Schizophrenese: A Private Language', *Journal of Health and Social Behaviour*, 2 (1970), 126-34 (p. 133).
[25] Anne M. Lovell, 'The City is My Mother: Narratives of Schizophrenia and Homelessness', *American Anthropologist*, 2 (1997), 355-68, (p. 356).

to be understood as more than *just* a psychiatric label.[26] If the self and the narrative have been colonised by psychiatric 'authority' – medicalised, disenfranchised, medicated, silenced – then lived experience of 'madness' remains mute (and, indeed, moot). The psychiatric interpretation of 'madness' is the one on which we rely to discuss 'madness', as other voices and discourses have been prevented from entering the vernacular. As Ochs and Capps argued, 'dominating stories that preserve the status quo can estrange and muffle alternative perspectives'.[27] However, the preservation of psychiatry's dominance has a very human cost.

Once the language problems have been established, I shall investigate the politics of narrating 'madness', beginning with a deconstruction of the narrative process. This is done not only to understand the significance of narratives – particularly their function in developing, affirming and externalising the self – but also in order to understand the role that these accounts play in our ability to interact with the world around us, essential to being an accepted social entity. A successful narrative has three fundamental components: it is an articulation of an experience of the self; it is communicated via a medium; it is delivered to a social audience.[28] According to narrative theorist Mieke Bal, 'a narrative text is a text in which an agent or subject conveys to an addressee […] a story in a particular medium'.[29] Ochs and Capps asserted that narratives are 'an essential resource in the struggle to bring experiences to conscious awareness', and therefore could be a tool to bring lived experience of 'madness' to the attention of the collective social consciousness.[30] But if a narrative holds

[26] Lacan, *Écrits*, p. 46.
[27] Ochs, 'Narrating the Self', p. 19.
[28] Judging narrative 'success' is a complex and contentious process, and one I unpick in greater detail later in this chapter. In brief, in order for a narrative to succeed, it must be socially accessible without jeopardising the authenticity of the self it attempts to communicate. A revealing example can be found in *Love's Work* by philosopher Gillian Rose. Halfway through her narrative, Rose asked her reader to consider: 'Suppose that I were now to reveal that I have AIDS, full-blown AIDS, and have been ill during most of the course of what I have related. I would lose you. I would lose you to knowledge, to fear and to metaphor. Such a revelation would result in the sacrifice of the alchemy of my art, of artistic "control"'. See Gillian Rose, *Love's Work* (New York: New York Review of Books, 2011), pp. 76-77.
[29] Mieke Bal, *Narratology: Introduction to the Theory of Narrative*, 3rd edn (Toronto: University of Toronto Press, 2009), p. 5.
[30] Ochs, 'Narrating the Self', p. 21.

so much power, why do we not hear of such experiences? Where does the narrative process fail in the case of 'madness' narratives? Are individual experiences simply ineffable? Is the conduit between self and society unsuitable? Or is the intended audience simply refusing to engage with 'madness' narratives in any meaningful way?

There are, of course, limitations to the three-stage narrative process; I am specifically exploring the viability of narratives in a social context. There is potential to argue that the narrator is simultaneously the creator and original audience for their narrative – particularly in the context of narration which serves a therapeutic purpose. My focus on social viability is not to ignore the vitally important process of self-narration. By exploring narratives which necessitate acknowledgement from a social audience in order to 'succeed', and the politics which obstruct this validation, I am able to employ narrative analysis in a way which examines and deconstructs the tumultuous relationship between mainstream society and the 'mad' 'other'.

This three stage approach also inevitably examines a narrative in isolation. In the ebb and flow of daily life, or hidden in the layers of a text, it is rare that narratives are encountered in such a pure state. Our response to a narrative is heavily influenced by the presence of paratexts. Literary theorist Gerard Genette argued that paratexts are 'a fringe of the printed text which in reality control […] one's whole reading of the text'.[31] Such framing occupies a 'privileged place of […] influence on the public': it is a conscious process of recontextualisation which only psychiatric hegemony – granted both a voice and an ability to silence other voices – may conduct.[32] These paratexts may be literal, such as an editor's note, a preface, an introduction, or metaphorical, such as the expectations one may harbour when a

[31]Gerard Genette, *Paratexts: Thresholds of Interpretation*, trans. by Jane E. Lewin (Cambridge: Cambridge University Press, 1997), p. 2.
[32] Genette, *Paratexts*, p. 2.

certain text is approached.[33] I explore the impact this framing has on the reception of such narratives: is it, in fact, this 'excess' material which obstructs the successful dissemination of a 'madness' narrative?This excursion into narratology is developed by exploring alternative models available to those experiencing 'madness'. In chapter four, I explore the possibility of using visual art as a medium for 'madness' narratives, as it is divorced from semantic politics. In this chapter, I discuss the relevance and merits of alternatives. If orthodox narrative models – or, indeed, conventional language – are unsuitable, how sustainable is it to create a *new* language to speak of 'madness'? The viability of these narrative platforms will be judged on their ability to communicate an experience of 'madness' without limiting or obscuring it, and on their accessibility and availability to a mainstream social audience.

This thesis is primarily concerned with the conflict between authenticity and accessibility: a battle waged around the politics and problems latent in the language *of* and *about* 'madness'.[34] I identify why psychiatric discourse is considered the hegemonic narrative of 'madness', rather than allowing society to hear from those living with and through 'madness'. As later chapters will show, this silencing is historic and entrenched, but it began with the genesis of psychiatry. Prior to the nineteenth-century asylum boom, 'madness' apparently represented what Foucault termed 'a difficult, hermetic, esoteric knowledge', bound with concepts of wisdom and spirituality.[35] By contrast, psychiatric intervention informed society that 'madness' was, instead, 'a kind of non-knowledge', a 'closed' text, a state of 'incomprehensibility'.[36]

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[33] When we open a crime novel, for example, we may expect it to conform to a certain model: the crime is discovered; clues are collected; the mystery is solved; the criminal apprehended. The metaphorical paratext here is composed of our expectations, and is rooted in our experience – or anticipations – of a particular genre.

[34] The word 'authentic' appears quite frequently in narratology. My use of this term denotes an authentic 'madness' narrative: one which communicates lived experience of 'madness' without being limited (by use of psychiatric discourse which reduces 'madness' to a list of symptoms and is burdened with stigma), obscured (by paratexts) or censored (for example, a narrative may be edited, or an experience of 'madness' deemphasised in order to maintain audience engagement).

[35] Foucault, *History of Madness*, p. 19.

[36] Tony Cutler, 'Lacan's Philosophical Coquetry', in *The Talking Cure*, ed. by Colin MacCabe (Hampshire: MacMillan, 1986), pp. 90-107 (p. 93).

This medicalisation of 'madness' has obscured its 'cosmic, tragic consciousness': the *humanity* of 'madness', its *soul*; its place in the context of life.[37] The means we have of understanding 'madness' – the current language available to signify mental illness – merely renders the experience misunderstood. As Laing observed, 'the mad things said and done by the schizophrenic will essentially remain a closed book if one does not understand their existential context'.[38] But can we ever acknowledge and situate 'madness' in an 'existential context' which grants it meaning when the only mainstream discourse available to talk of 'madness' is the language of 'observation and classification'?[39]

Stigma and Semantics: The Politics of Taxonomy

Psychiatric labels applied to those experiencing 'madness' can be understood as a kind of verbal panopticon. The panopticon is, in brief, an institutional building designed on the premise that the detained are always visible: an idea proposed by English philosopher Jeremy Bentham. Bentham explained the mechanics of this design as follows: 'the building circular […] the prisoners, in their cells, occupying the circumference – the officers [occupying] the centre […] By blinds and other contrivances, the inspectors concealed […] hence the sentiment of a sort of invisible omnipresence'.[40] According to Foucault, this model was designed 'to induce […] a state of conscious and permanent visibility that assures the automatic functioning of power'.[41] Of the detained – the *watched* – Foucault explained, 'he is seen, but he does not see; he is the object of information, never a subject in communication'.[42] The panopticon model has relevance to asylum culture in more ways than

[37] Foucault, *History of Madness*, p. 27.
[38] Laing, *Divided*, p. 17.
[39] Foucault, *History of Madness*, p. 488.
[40] Jeremy Bentham, quoted in The Committee of the Society for the Improvement of Prison Discipline, *Remarks on the Form and Construction of Prisons with Appropriate Designs* (London: Richard Taylor, 1826), p. 65.
[41] Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. by Alan Sheridan (Harmondsworth: Penguin, 1991), 201.
[42] Foucault, *Discipline*, p. 200.

one: on a fundamental level, numerous nineteenth-century asylums were constructed using Bentham's design or at least inspired by his principles.[43] However, there is also a metaphorical connection, through which the politics of psychiatric discourse can be understood further.

The significance of the Foucauldian panopticon lies in the disenfranchisement of the individual, and the enforcement of power. This process also occurs with a psychiatric diagnosis, a label that *exposes* the individual without *engaging* them. As with the inmate in the panopticon, those declared 'mad' become 'the object of information [but] never a subject in communication'.[44] Immediately, there is a process of marginalisation – represented by the inmate banished to the circumference of the institution, rather than the centre – and objectification. The individual branded with a psychiatric label becomes 'pure spectacle and absolute subject': the watched, the documented, the ostracised, spoken *of* but not *to*.[45] Much like the inmate who is exposed to the officer's gaze but not able to return it, the 'mad' individual is the subject of psychiatric discourse, but not part of its dialogue.

How is it that a single word – 'schizophrenic', 'psychotic', 'bipolar' – can wield such power? In order to understand the relationship between taxonomy (the words) and stigma (the assortment of social misconceptions, assumptions and moral judgements inherent in such labels), one must take a step back. How are words assigned a value, a *thing* to signify? How does language become so burdened with meaning, so laden with social implications? By approaching taxonomy through a Saussurean lens, I establish how this process takes shape – and, by association, investigate the possibility of it being reversed.

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[43] See, for example, John Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* (London: John Churchill, 1847), p. 26. Here, psychiatrist Conolly explained the function of the 'inspection-plate': 'The plate is made of iron, and towards the gallery merely presents a flat surface and a small circular opening, over which there is a cover, which moves without noise […] the inside of the plate is broad and concave towards the patient's room, all parts of which thus become visible'. Examples of asylums constructed using the panopticon model include Glasgow asylum and Wakefield asylum.
[44] Foucault, *Discipline*, p. 200.
[45] Foucault, *Civilization*, p. 262.

Saussure argued that although we may have the physical capacity of speech (for example, vocal chords), we are unable to communicate without the *langue* – a language system, unique to each culture, which attributes shared, social meaning to the physical and written sounds of speech. *Parole* – the physical act of speech in the individual – requires the *langue* to be rendered a form of communication: 'speech sounds are only the instruments of thought, and have no independent existence [without] combin[ing] with an idea to form [a] complex unit'.[46] The *langue* is comprised of connections between spoken words and ideas, a process Saussure termed 'signification'. Therefore, when I vocalise the word 'tree' to someone else who has been initiated into and has explicitly consented to the *langue* of my culture, that word (the signifier, or acoustic image) allows the other person to understand that I am referring to a large perennial plant, with branches, a trunk, and roots. The psychological imprint triggered by the word 'tree' is termed the signified, the concept, 'as given to him [the other party, who is being spoken to] by the evidence of his senses'.[47] The process of acquiring language is 'a kind of apprenticeship in order to acquaint himself [the child] with its workings': it is absorbed through social osmosis from a young age.[48] This 'apprenticeship' is necessary for social engagement: without an acceptance of the *langue*, the words one speaks have not been assigned any shared meaning, and communication is obstructed.

To continue with my previous example, the process of signification allows me to talk to my companion about a tree, with the other person able to recognise what it is that I am talking about. It also means that we – as a society – have signifiers on which we rely to communicate and talk about anything, including states or objects which are not neatly contained in a single word.[49] There is, for example, a vast array of human experience limited

[46] Saussure, *General Linguistics*, p. 9.
[47] Saussure, *General Linguistics*, p. 66.
[48] Saussure, *General Linguistics*, p. 14.
[49] My use of the plural personal pronoun here refers to a group of people who share a *langue*; a society reliant on a shared understanding of the signifier and the signified to communicate. Any further references to the *langue* refer specifically to the language I encounter in my Western, Anglophone context.

to the signifier ‘schizophrenic’. I mentioned earlier that taxonomy is the enforcement of signification: it connects the signified (the individual) with a signifier (the label), and thus reduces the signified to the signifier. Multi-faceted lives, experiences and people are relegated to a single word: an acoustic image which, as I have already established, denotes ‘otherness’ and leads to such individuals being ‘invalidated as […] human being[s]’.[50]

At present, Western psychiatry predominantly uses the *DSM* to give ‘madness’ language: in a Saussurean sense, the *DSM* functions as a kind of dictionary, allowing psychiatrists to attach a signifier (a diagnostic label) to the signified (the individual) under their jurisdiction. From a psychiatric perspective, it allows chaotic patterns of symptoms to be reined in to a diagnosis, and – in theory – it ensures that there is a universal language system in psychiatry so that the diagnostic process can be consistent.[51] Despite Saussure’s assertion that ‘once the language has selected a signal, it cannot be freely replaced by any other’, psychiatry has created and evolved its own *langue* – thus, ‘dementia praecox’ became ‘schizophrenia’ and its numerous subsections, ‘melancholia’ became ‘depression’, ‘manic depression’ became ‘bipolar’, to name but a few. A Saussurean interpretation reveals that, as psychiatry has ‘a *community of speakers*’ – bestowed with the ‘authority’ associated with their profession – these factors have allowed its *langue* not only to merge with the overarching *langue* of the Western world, but additionally to become the sole discourse for discussing ‘madness’.[52] It is possible that the issues latent in creating a new *langue* may be accountable for at least part of the ‘madness’ language problem.

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[50] Laing, *Politics*, p. 101.

[51] By this, I mean that all psychiatrists using the *DSM* are able to access the same criteria and language so that a ‘patient’ presenting with – for example – ‘delusions’, ‘poverty of speech’ and ‘incoherence’ which have persisted for over six months would consistently receive a label of ‘schizophrenic’ regardless of which psychiatrist diagnosed him/her. Psychiatrist Robert Spitzer – part of the taskforce for the later editions of the *DSM* – attempted to address this ‘reliability problem’ with increasingly detailed and specific criteria. However, a 2007 study in *Psychiatry* journal reports that 86 per cent of psychiatrists asked still felt that diagnostic reliability was poor. See Davies, *Cracked*, p. 18.

[52] Saussure, *General Linguistics*, p. 77. Italics added for emphasis.

Understanding taxonomy in terms of signification presents a paradox. This language – terms such as 'schizophrenic' and 'bipolar' – is too limiting and too imprecise. The initial issue – that taxonomy is too limiting – is a direct result of medicalising human experience. One term will never fit all. The *DSM*-based diagnostic model examines symptoms in isolation, failing to acknowledge the overarching picture: the context of this distress in the life and experience of the individual. 'Madness' is approached and diagnosed as a 'clinical entity': labels which do not consider the contextual aetiology and significance of mental distress.[53] The human *excess* – the surplus material which is not considered relevant to the *DSM* criteria, the suffering, grief and trauma which threaten to render 'madness' familiar – remains unspoken, beyond the realm of taxonomy. Psychiatric discourse reduces and limits the individual to a framework of symptoms.

However, this clinically meticulous approach of imposing order onto the organic *dis*order of human experience stands in contrast to the evasive and unstable meaning of psychiatric terms in a social context. According to Saussure, language 'is intrinsically defenceless against the factors which constantly tend to shift relationships between signal and signification'.[54] In the social realm, the signifier 'schizophrenic' evokes an array of concepts.[55] It could suggest an individual who hears voices instructing them to commit violent acts; someone who is convinced that they have superhuman powers; who is crippled by paranoia; who is plagued by visual hallucinations; who has a split personality; someone who rants and raves inappropriately.[56] To someone who has just seen the film *Fight Club*, it might denote a sort of 'dissociative identity disorder'.[57] For one who has just seen *Girl,*

[53] Laing, *Divided*, p. 18.
[54] Saussure, *General Linguistics*, p. 76.
[55] 'Concepts' is a Saussurean term, interchangeable with 'signified'.
[56] In chapter five, I discuss the social assumption that 'madness' equates to violence in more detail. I also explore the wider role that popular discourses of 'madness' plays in shaping societal perspectives and enforcing stigma.
[57] This confusion of 'schizophrenia' and 'dissociative identity disorder' is – in addition to being a popular Hollywood trope – rooted in the etymology of the term 'schizophrenia'. I will discuss this in more detail shortly.

Interrupted, it could suggest someone who, like the character Polly Clark, is depersonalised to the extent that they have no idea who they are, or what they look like. Psychiatric labels become so 'burdened with attributes, signs, allusions that they finally lose their own form […] between the knowledge which animates it [the social discourse] and the form into which it is transposed [the psychiatric category], a gap widens'.[58] If the signified is so inconsistent, how can the signifier truly signify anything when it is fraught with too many – and often contradictory – meanings?[59]

According to Saussure, the social evolution of language is inevitable: the signifier and the signified transform as the *langue* passes on from generation to generation. However, Saussure argued that although creating an 'artificial' *langue*[60] was possible, maintaining control of it was not:

> Anyone who invents an artificial language retains control of it only as long as it is not in use. But as soon as it fulfils its purpose and becomes the property of the community, it is no longer under control […] Once launched, the language will in all probability begin to lead a semiological life of its own.[61]

Psychiatric taxonomy has become autonomous – 'lead[ing] a semiological life of its own' – which has warped, distorted and further estranged such terms from the individual they attempt to signify. This semantic evolution has led to a 'cultural legacy of misrecognition'.[62] Psychiatric language was imperfect to begin with, and its multi-faceted presence in the mainstream social sphere reduces still further the possibility of 'madness' being known.

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[58] Foucault, *Civilization*, pp. 18-19.

[59] I am not suggesting that this is an issue exclusive to mental illness: misuse and misappropriation of terminology which obscures meaning does happen in other experiences of illness, too. However, this semantic obfuscation occurs more frequently in the sphere of mental illness, as, for example, 'A 2007 study of the terms "schizophrenia" and "schizophrenic" in the UK national press found that 11% of references were metaphorical, with broadsheet papers more likely to deploy such phrasing than tabloids. By contrast, cancer was only used in this manner in 0.02% of cases'. See Jon Kelly and Denise Winterman, 'OCD, Bipolar, Schizophrenic and the Misuse of Mental Health Terms', *BBC News Magazine*, 10 October 2011 <http://www.bbc.co.uk/news/magazine-15213824> [accessed 16 October 2015].

[60] By 'artificial langue', I mean an inorganic language such as psychiatric taxonomy: one consciously constructed, rather than one shaped in use over time.

[61] Saussure, *General Linguistics*, p. 76.

[62] Cross, *Mediating Madness*, p. 7.

Foucault observed that the crude psychiatric classifications of the nineteenth century – terms which signified the origin of taxonomy as we know it today – 'ultimately functioned as little more than images, whose value lay in the vegetal myth that they contained within them'.[63] Thus, although the social distortion of psychiatric language is partly to blame for stigma, a Foucauldian interpretation would suggest that such taxonomy was *burdened* with meaning – indeed, burdened with 'myth[s]' – at its genesis. Is there something inherent in the etymology of these terms which has caused what anti-psychiatrist David Cooper described as a 'perpetual slipping over of words': an innate disconnect between the signifier and the signified, or the presence of too many concepts under the bracket of a single, unstable signifier?[64]

An investigation into the label of 'schizophrenia', for example, exposes a fracture between the signifier and the signified. The origin of 'schizophrenia' can be found in Kraepelin's use of the term 'dementia praecox', following his textbook of the same name, which was published in 1896. The Latin etymology of the prefix 'dement' is to be 'out of one's mind', developing into the noun 'dementia' which suggests a decline or total failure of one's mental capacity.[65] The term 'praecox' has its origins in the Latin adjective *precoce*, which signifies an 'early or precocious ripening'.[66] 'Dementia praecox', in its entirety, denotes a 'patient' who goes 'out of one's mind' at an early age, supported by Kraepelin's own declaration that 'these peculiar dementias seemed to stand in near relation to the period of youth'.[67] Kraepelin intended the label to be used until 'a profounder understanding would

[63] Foucault, *History of Madness*, p. 194.
[64] David Cooper, *The Language of Madness* (Harmondsworth: Penguin, 1978), p. 20.
[65] *OED*, 'dement' <http://www.oed.com/view/Entry/49628?rskey=9gTFKM&result=1&isAdvanced=false#eid> [accessed 17 June 2011].
[66] *OED*, 'precoce' <http://www.oed.com/view/Entry/149685?rskey=yaco0g&result=1&isAdvanced=true#eid62674979> [accessed 17 June 2011].
[67] Kraepelin, *Dementia Praecox*, p. 4.

provide an appropriate name'.[68] However, as the term 'schizophrenia' is loaded with *mis*understanding, to what extent can it really be considered an 'appropriate name'?

The label 'schizophrenia' was formulated by Bleuler in 1908, developing Kraepelin's hypothesis of 'dementia praecox', with a view to 'renaming the disease to focus on a splitting of usually integrated psychic functions'.[69] The etymological foundations of the term reveal Bleuler's intentions to represent the condition as one which 'contradict[s] one of the most fundamental assumptions of our culture [...] the Western conception of the person [...] organized into a distinctive whole'.[70] The prefix 'schizo' denotes a 'split', cleaving or division.[71] When coupled with the adjective 'phrenic' ('of or relating to the mind'), the label evokes a fragmented mind, a divided self, and a split personality, thus corresponding with and engendering the popular social construction of 'schizophrenia' as a form of 'dissociative identity disorder'.[72] Laing offered yet another interpretation of the etymology of 'schizophrenia': '*Schiz* – "broken"; *Phrenos* – "soul or heart". The schizophrenic in this sense is one who is broken-hearted'.[73] This emotive and empathetic interpretation of 'schizophrenia' stands in stark contrast to the psychiatric meaning of the term.[74]

The public perception of 'schizophrenia' has taken on substance and meaning beyond the psychiatric construct. A brief excursion into the etymology of 'schizophrenia' reveals that societal (mis)use of the term is not entirely liable for this inconsistency. These popular

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[68] Ibid.
[69] Irving I. Gottesman, *Schizophrenia Genesis: The Origins of Madness* (New York: W. H. Freeman and Company, 1991), p. 8.
[70] Louis A. Sass, 'Introspection, Schizophrenia, and the Fragmentation of the Self', *Representation*, 19 (1987), 1-34 (p. 1). The etymology of the term 'individual' originates from classical Latin – *indīviduus* – referring to something *indivisible*. See *OED*, 'individual' <http://www.oed.com/view/Entry/94633?redirectedFrom=individual#eid> [accessed 18 September 2015].
[71] *OED*, 'schizo-', <http://www.oed.com/view/Entry/172402?rskey=rUOfTb&result=2&isAdvanced=false#id> [accessed 17 June 2011].
[72] *OED*, 'phrenic', <http://www.oed.com/view/Entry/142968?rskey=N6Lfk&result=7&isAdvanced=false#> [accessed 17 June 2011].
[73] Laing, *Politics*, p. 107.
[74] Compare Laing's compassionate interpretation of 'schizophrenia' as a broken heart or soul with psychiatrist Peter F. Liddle's 'three syndrome hypothesis' which defines 'schizophrenia' with terms such as 'psychomotor poverty', 'reality distortion' and 'disorder of internal monitoring'. See David Semple and Roger Smyth, *Oxford Handbook of Psychiatry* (Oxford: Oxford University Press, 2013), p. 173.

stereotypes of the condition (particularly the assumption that 'schizophrenia' equates to a split personality, or a split self) materialised after the term 'schizophrenia' had been developed, as 'many people came to believe that schizophrenics display multiple, or split, personalities'.[75] This conviction is still prominent today. A 2008 American survey, conducted by the National Alliance on Mental Illness, reported that 'the greatest misconception [held by 64% of participants] is that "split or multiple personalities" are symptoms of schizophrenia'.[76]

Psychiatric terms came into being in imperfect forms; never able to signify all that they were meant to, never able to encompass the variants of human experience they were attached to. Borne out of unstable etymology, psychiatric *langue* does not seem to translate into a broader social context without expanding, taking on new life and new meanings. Perhaps this is the fault of those who initially devised such terms; perhaps this is an inherent issue in applying clinical taxonomy to a phenomenon which resists pathological classification. Regardless, psychiatric discourse is flawed and laden with stigma, and the societal interpretation of such terms renders their use even more problematic.

If, according to Lacan, 'the self is "absolutely nothing" apart from its being constituted by language', and the semantics available to give that self meaning are tainted, inappropriate and damaging, can we ever really appreciate how utterly devastating that can be?[77] Do we really know how radical an impact this language has on identity, on the self – fragile but essential concepts which must be entirely revised to accommodate these new labels? The first language problem is a battle for selfhood against the pressure of limited and misinformed labels, which usurp identity during a psychiatric intervention. And yet –

[75] Gottesman, *Schizophrenia Genesis*, p. 8.
[76] National Alliance on Mental Illness, 'Schizophrenia: Public Attitudes, Personal Needs' <http://www.nami.org/schizophreniasurvey> [accessed 27 November 2015].
[77] Berthold, 'Talking Cures', p. 305.

disconcertingly – this is not the only semantic war waged between psychiatrist, 'patient' and society.

Comprehending the 'Incomprehensible': Language Use as a Symptom

I have already briefly discussed the psychiatric reliance on the speech of the 'patient': as explained by Lacan, in the 'patient'/psychiatrist dynamic, this narrative is the 'single medium'.[78] Through what the 'patient' says or how the 'patient' speaks, the psychiatrist is able to identify symptoms and apply diagnostic labels. In theory, if the speech of the 'patient' is a fundamental resource, then the 'mad' voice is granted significance: it is important, it is relevant, it is listened to. However, the psychiatric approach is less concerned with content of speech – the history of the 'patient', understanding 'madness' in an anthropological and personal context – and instead focuses on its anomalies: *how* ideas are presented, and what the 'patient' is not doing according to the 'norm'. Rather than opening up a dialogue, psychiatry analyses speech without engaging with what is being said: a manoeuvre which clearly signals an entrenched reluctance to listen to those labelled 'mad'.

Before the medicalisation of language use is investigated further, this concept can be illuminated by an exploration of Lacanian theory, particularly his premise of the *nom du père* (the Name-of-the-Father). *Nom du père* refers to 'the whole complex of rules, interdictions, concepts, and words that the child must accept to transit successfully […] into the larger practical and social world'.[79] This 'complex of rules' establishes and maintains the Symbolic Order: the social sphere of linguistic communication, conventions and relations with others.

Lacan described 'psychosis' as the antithesis of the *nom du père*: a deviation from conventional language structure, and a rejection of conventions which preserve the status

[78] Lacan, *Écrits*, p. 44.
[79] Louis A. Sass, 'Madness and the Ineffable: Hegel, Kierkegaard, and Lacan', *Philosophy, Psychiatry and Psychology*, 4 (2009), 319-24 (p. 321). For a more detailed discussion of *nom du père*, see Jacques Lacan, *The Psychoses: The Seminar of Jacques Lacan*, trans. by Russell Grigg, ed. by Jacques-Alain Miller (London: Routledge, 1993).

quo. According to Lacan, a 'patient' may employ 'new compound words […] governed […] by the rules of the patient's language'.[80] A new, independent language is crafted and, with it, the autonomy of the individual is developed: they are not subject to the grand Symbolic Order but to their own order. This *refusal* to conform to the 'complex of rules' of the *nom du père* 'is the defining feature of psychosis. As a result of this failure, the madman is incapable of experiencing a meaningful world or of having a coherent sense of existing as a subject of language or experience'.[81] By not being part of the Symbolic Order, the experience of the 'madman' is invalidated. As 'madness' does not conform to the conventional language structure, its voice is not heard. An inability or reluctance to be subject to the *nom du père* prevents the individual from engaging and being heeded in a social context: 'The person who attempts to turn away from language and social communication [….will] be forfeiting the very possibility of access to the external world'.[82] Without a *langue* to grant it meaning, a narrative which deviates from orthodox signification is merely 'empty speech'.[83]

According to Lacan, 'it is the lack of the Name-of-the-Father [during 'psychosis' which] sets off the cascade of reshaping of the signifier form'.[84] Indeed, Hegel argued that 'madness' can be restored to 'sanity' once the 'authority' of the *nom du père* – signified by a return to conventional language use – is reinstated: 'cure must be sought in the re-externalization (rebirth) of the self into relations with others *through a path back to language*'.[85] However, when one is discussing seemingly abstract theory, it can be difficult to appreciate the true impact such ideas have in practice. Can 'madness' really be seen to reveal itself in an innocuous 'reshaping of the signifier form'?

[80] Lacan, *Écrits*, p. 204.
[81] Sass, 'Ineffable', p. 321.
[82] Sass, 'Ineffable', p. 320.
[83] Lacan, *Écrits*, p. 46.
[84] Lacan, *Écrits*, p. 240. Italics added for emphasis.
[85] Berthold, 'Talking Cures', p. 306. Italics added for emphasis.

According to psychiatry, anomalies which can be identified in the speech of the 'patient' include 'incoherent speech […] poverty of content of speech or loss of goal […] lack of spontaneous, self-initiated speech […] perseveration […] unintelligible speech, with a lack of proper connections between words'.[86] The symptoms a psychiatrist looks for when diagnosing 'schizophrenia' include 'disorganized speech [and] incoherent speech, diminished experience and expression of emotions'.[87] A 'manic' state reveals itself through 'circumstantial thinking: a disorder of the form of thought where irrelevant details and digressions overwhelm the direction of the thought process. This abnormality may be reflected in the resultant speech' and 'clang association: an abnormality of speech where the connection between words is their sound rather than their meaning'.[88] Another psychiatric textbook explained that:

> The speech often reflects an underlying thought disorder […] there is a vagueness in the patient's talk that makes it difficult to grasp meaning […] Thought disorder is reflected in the loosening of association between expressed ideas […] the structure and coherence of thinking is lost, so that utterances are jumbled (word salad or verbigeration). Some patients use ordinary words or phrases in unusual ways (metonyms or paraphrases), and a few coin new words (neologisms).[89]

As these extracts demonstrate, psychiatry searches for evidence of 'madness' in unorthodox language use. 'Madness' manifests itself in a deviation from the process of signification – using 'ordinary words' in 'unusual ways', thus disregarding the social practice of applying a signifier to the signified in accordance with the *langue*. 'Madness' also transgresses cultural codes of the 'norm' of communication: rather than expressing experiences in a clear, focused and accessible manner, 'madness' narratives are apparently rendered 'incoherent' by repetition, digressions and 'improper' connections between words.[90] Lacan asserted that 'as a

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[86] Frith, 'Language and Communication, p. 10.
[87] Keefe, *Understanding Schizophrenia*, p. 22.
[88] Semple, *Handbook*, p. 84.
[89] Cowen, *Textbook of Psychiatry*, p. 256.
[90] Of course, were *anyone's* speech to be analysed and dissected so meticulously, anomalies would present themselves. Digression and repetition commonly feature in speech patterns, and a diminished ability to 'express'

result of this failure [to conform to conventional language], the madman is incapable of experiencing a meaningful world'.[91] This medicalisation of language use severely impacts on the social identity of those labelled 'mad'. If mainstream society is informed that 'madness' is 'incoherent' and 'unintelligible', then there is no incentive to listen to or acknowledge such experiences. Diminishing the perceived value of individual discourse – establishing it as *non*-communication – ensures that the 'mad' voice is silenced. Porter declared that in 'mainline views in psychiatric medicine […] it became standard to refer to what mad people said […] through terms such as "chattering", "jabbering" and "ranting"': a manoeuvre designed to ensure 'madness' narratives remain 'closed' texts.[92]

This medicalisation of language use also establishes the politics of the 'patient'/psychiatrist relationship. The psychiatrist acts as an interpreter; a psychiatric diagnosis is depicted as 'a thoroughly semiotic activity: an analysis of one symbol system followed by its translation into another'.[93] The individual experiencing 'madness' is now constructed as dependent on psychiatric authority because – apparently – only psychiatry can access their narratives (despite, as I mentioned earlier, such access being detached analysis, rather than actually listening).[94] The narrative of the 'patient' is decoded to reveal the symptoms of an illness: that is all that the narrative is 'allowed' to signify. The experience of the 'patient' is depicted as having no place outside of the 'patient'/psychiatrist (and, indeed, translator) relationship. 'Madness' narratives cannot be socially viable because the 'authority' has declared them 'entirely on the side of nonsense'.[95]

I discuss the impact that the interpretation of language use as a symptom has on 'madness' narratives in more detail shortly, but before I move on to narratology, the issue of

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emotions is primarily influenced by context and the preference of the individual. It is worth considering to what extent these alleged indicators of 'madness' feature in apparently 'sane' everyday discourse.

[91] Sass, 'Ineffable', p. 321.

[92] Porter, *Social History*, p. 32.

[93] Arthur Kleinman, *The Illness Narratives* (New York: Basic Books, 1988), p. 18.

[94] Davies, *Cracked*, p. 219.

[95] Foucault, *History of Madness*, p. 392.

culpability must be addressed. Who is to blame when language fails? Freud described the fraught relationship between 'madness' and language as a 'failure of translation'.[96] However, is this due to the individual labelled 'mad' being unable, or reluctant, to translate their experiences into universally known signifiers? Is it the fault of the psychiatrist – assuming the role of interpreter – who misunderstands the signifiers of the 'patient'? Or is this a flaw of the dominant language system, which prevents a lived account of 'madness' from being a socially accessible narrative?

A Lacanian approach would deem the 'patient' culpable for the language problem. This is because 'madness' lies in a rejection of the *nom du père* in favour of being autonomous – or in the hope of finding an authentic language of 'madness', 'governed […] by the rules of the patient's language'.[97] Thus, if society is unable to access or empathise with 'madness' narratives, this is because the 'patient' has refused to conform to the overarching language system which allows experiences to be understood, recognised, and granted meaning. The 'patient' has, in effect, chosen to speak – or create – another language, a network of neologisms: the resulting narrative is deemed 'incomprehensible'.

However, when one discusses *poverty of speech*, one does not consider *poverty of listening*. Saussure offered a different perspective. When we encounter a language we do not understand, we do not blame the speaker for *our* inability to comprehend. Saussure explained that 'we hear the sounds but we cannot enter into the social reality of what is happening, because of our failure to comprehend'.[98] This, in contrast, makes the listener accountable: there is not a failure in communication, but a failure in *translation*, in how the narrative is received.[99] Kraepelin argued that 'incoherence' reveals the individual's inability to procure sound judgement: '[The 'patient'] cannot grasp a thought, cannot understand anything: their

[96] Freud, *Complete Letters*, p. 208.
[97] Lacan, *Écrits*, p. 204.
[98] Saussure, *General Linguistics*, p. 13.
[99] This concept inevitably overlaps with narratology and so will be discussed in further detail shortly.

mind is scattered; their thoughts have flowed away; their brain is no longer competent, is enfeebled'.[100] However, the inability to comprehend – to 'understand anything' – is a principal trait of the psychiatrist rather than the 'patient'.[101] This suggests that, as listeners, we must adapt to what we hear, rather than expecting narratives to conform to what we recognise and are able to 'understand' immediately.

Rather than placing culpability with 'poverty of speech' or 'poverty of listening', is there potential to challenge the assumption that narratives have to be 'coherent' and conformist in the first place? It seems that the subjectivity of an experience of 'madness' stands in binary opposition to the neat, regulated structure of signification and conventional language use. In the midst of trauma, upheaval, grief and suffering, it is absurd to expect such intense and intimate narratives to conform to arbitrary notions of 'coherence' or 'comprehensibility'. As Cooper asserted:

> The madman will have none of this! [...] He refuses to have his existence reduced to nice proper grammar, and has no use for the psychoanalyst three yards away, staring into another space, listening only to 'It' and not to things said about real collective social experience. For the madman it is of no interest that the 'unconscious is structured like a language' – *it is language that must be structured like the 'unconscious'*.[102]

That 'madness' cannot be articulated or contained in orthodox language does not mean that it should be silent. Instead, we should be allowing language to be modified, deconstructed and reconfigured – much like the self through an experience of 'madness'. If society disregards everything it does not immediately understand, we are at risk of silencing a multitude of vibrant and dynamic alternative narratives, from 'madness' and other illness narratives, to narratives of drug use, dreams or dream-like states, religious and spiritual experiences, and streams of consciousness.

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[100] Kraepelin, *Dementia Praecox*, p. 26.
[101] By referring to 'madness' as a state beyond comprehension, psychiatry is admitting to *not understanding* although, of course, psychiatry blames the 'mad' individual for being 'incoherent', rather than accepting any responsibility.
[102] Cooper, *Language of Madness*, pp. 21-22. Emphasis in original.

The Language *of* 'Madness': Narrating Lived Experiences

I have investigated the language problem from a semantic perspective. In order to identify the obstacles which prevent 'madness' from being heard, I will now approach this problem through the lens of narrative theory, and consider viable solutions.

Of paramount importance is establishing what a 'narrative' is, in order to understand the interplay between self, narrative and society, and to ascertain where this process fails when it comes to narrating 'madness'. Ochs and Capps argued that narratives 'interface […] self and society, constituting a crucial resource for socializing emotions, attitudes and identities, developing interpersonal relationships, and constituting membership in a community'.[103] Narrative theorist H. Porter Abbott contended that 'we only know ourselves insofar as we are narrativized [as] it is only though narrative that we know ourselves as active entities', thus if an individual is unable or reluctant to share a narrative, they are at risk of social and personal estrangement. [104] If one is unable to be part of the communal discourse of narrative exchange, one cannot identify as a proactive, social being.

However, in addition to social necessity, a narrative is also a vital resource for constructing and disseminating identity. The act of narration has been described as 'profoundly human', 'a transformative force […] provoking self-reflection'.[105] It is a space in which the self can be assembled and affirmed; it is a reflective medium which can impose order onto chaos; it is a way for us to contemplate and communicate our history, our present and our future. A narrative 'give[s] form (or meaning) to the chaos and uncertainty

[103] Ochs, 'Narrating the Self', p. 19.
[104] H. Porter Abbott, *The Cambridge Introduction to Narrative* (Cambridge: Cambridge University Press, 2002), p. 123.
[105] Rhiannon Crawford, Brian Brown and Paul Crawford, *Storytelling in Therapy* (Cheltenham: Nelson Thornes, 2004), p. 2.

characteristic of the flux of life'.[106] Psychiatrist and anthropologist Arthur Kleinman explained that, in the event of a distressing experience such as severe illness, 'we are shocked out of our common-sensical [*sic*] perspective on the world. We are then in a transitional situation in which we must adopt some other perspective on our experience'.[107] A narrative of an illness experience (called 'pathography') does not only help us orientate ourselves during such trauma, but it can also allow us to communicate our suffering to those around us, garnering both support and social validation.[108]

The conventional process of narration can be stripped down to three fundamental stages. If any one of these components is not present or does not function, the narrative does not serve its purpose of allowing the self to be an active social entity.[109] First, it begins with the individual: the narrative is an articulation of the experiences of the self. Second, the narrative is communicated via a vehicle, most frequently language, varying from speech to the written word. Finally, the narrative needs to be delivered to – and *validated* by – a social audience.

As the final and perhaps most fundamental stage in the process, what does narrative validation look like, and what does it mean? Writer Roy Wolcott defines narrative communication as 'the transmission of *meaningful* messages to someone else with the aim of having him believe the information', which seems somewhat subjective: how does one measure what is meaningful or not, or meaningful enough?[110] That the recipient must believe the information is a problematic assumption: in everyday discourse, we receive a great deal of information which we do not believe, and yet this does not make it failed

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[106] Sam Migliore, 'From Illness Narratives to Social Commentary: A Pirandellian Approach to "Nerves"', *Medical Anthropology Quarterly*, 1 (2011), 100-25 (p. 118).
[107] Kleinman, *Illness Narratives*, p. 27.
[108] For more on the politics of 'pathography', see Paul Crawford and others, *Health Humanities* (Hampshire: Palgrave Macmillan, 2015), pp. 38-59.
[109] When I discuss narrative models used to articulate 'madness' shortly, I will establish the various pitfalls of these narratives, including demonstrating what happens when there are gaps or omissions in this three stage process.
[110] Wolcott, 'Schizophrenese', p. 126. Italics added for emphasis.

communication.[111] However, Wolcott established the crux of the narrative process: information is conveyed by one party and then accepted by the other, and this is the essential component which validates communication. If the success and significance – how 'meaningful' it is – of a narrative is ascertained by the reaction of the audience (whether or not the information is believed, according to Wolcott), then the power of judging narrative worth lies entirely with the listener. Once the narrative is delivered to its audience, it falls beyond the narrator's control. Neither the narrator nor the narrative dictates success; only the audience has the power of validation. In a psychiatric context, the psychiatrist acts as an additional obstacle to this validation process, judging narrative worth and, by virtue of assumed 'authority', informing the audience (mainstream society) accordingly.

Authentic 'Madness' Versus Accessible 'Madness': Where the Narrative Process Fails

Earlier, I used a theoretical lens to reflect on who is deemed culpable for what Freud ambiguously termed a 'failure of translation'.[112] A similar investigation needs to identify who is responsible when a narrative fails. I have established that a conventional narrative model has three stages: an articulation of the self; communication via a vehicle; delivery to a social audience. With each step, there is an opportunity for failure, and for the entire process to become unravelled. Is the self to blame for attempting to verbalise something inaccessible, something which does not fit with the chosen narrative medium, or which does not engage the intended social audience? Is the narrative model liable: is the chosen language too limited, or does the vehicle prevent mainstream social dissemination?[113] Or, is the intended social audience liable, for misinterpreting the narrative, not validating it, or just not listening?

[111] This can range from dialogue with friends and colleagues, to discourses in popular culture (weather forecasts, politician's speeches, and newspaper headlines, to name but a few examples).
[112] Freud, *Complete Letters*, p. 208.
[113] For example, in chapter four I discuss the viability of the Outsider Art genre as a vehicle for 'madness' narratives. Due to its marginal position in relation to the art world, anything produced under the 'Outsider Art'

A narrative – and the experience of the self it attempts to articulate – can only be constructed using the available resources. Psychiatry supplies the mainstream language available for talking about 'madness'. It is a language of categorisation, alienation and 'othering'. A personal narrative formulated through these terms is one which falls short in communicating an authentic sense of what 'madness' is – this discourse speaks of psychiatry's experience of 'madness', but not lived experience. Although it is language which is socially familiar, to use it to construct an individual narrative is an absurd kind of ventriloquism. Such narratives would be socially heeded, but they contribute to the legacy of misrepresentation which characterises popular discourses of 'madness'. This further reinforces the status quo which validates one empirical narrative (that of psychiatry) over another (personal experience).

'The expression of madness exceeds what [it] is possible to talk about using conventional psychiatric discourse', and yet, currently, it is the only language in the developed world available to discuss the 'madness' experience in a manner which is socially validated.[114] A narrative must jeopardise an authentic expression of the self in favour of being accessible and being heard: the self must be constructed using limited and damaging psychiatric terms. The narrative process remains incomplete, as, in order to engage with the wider social context of readership and exchange, one sacrifices the self: personal experience of 'madness', again, remains mute.

Unable to formulate a narrative divorced from psychiatric rhetoric which 'shapes public discourse on mental health', the individual experiencing 'madness' has two available options.[115] As I have already established, a narrative may be constructed through words which 'do not exist in a neutral and impersonal language, but *in other people's mouths, in*

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bracket will always be 'outsider' and thus 'other'. This prevents such narratives from reaching a mainstream audience.

[114] Cross, *Mediating Madness*, p. 29.

[115] Cross, *Mediating Madness*, p. 7.

other people's contexts'.[116] Personal experience of 'madness' is reduced to limited psychiatric lexis. The popular discourse of 'madness' continues to be (mis)informed by this hegemonic discourse, as lived experience is not always socially validated and therefore not known in a mainstream context.

The alternative is to communicate 'madness' through an unorthodox medium which is able to accommodate and articulate lived experience. In chapter four, I discuss how art can be used as a narrative model divorced from the politics of language. Other options include use of self-created language (such as 'schizophrenese'), postmodern narratives and narratives constructed in anti-psychiatric and 'survivor' communities.[117] Such narratives are able to communicate authentic 'madness' – an experience not limited to, distorted or censored by psychiatric language – and therefore the first two stages of the narrative process are complete. However, as these semantics or models deviate from conventional modes of communication, the final part of the process – delivery to a social audience – is forfeited. Unorthodox but authentic 'madness' narratives contradict psychiatric hegemony by refusing to be limited to its language. However, because such 'madness' narratives are formulated beyond psychiatric discourse – the known *langue* available to discuss 'madness' – they are socially unfamiliar. Deemed 'abstract', or unworthy of interpretation, 'conceived as unintelligible or non-sense', these narratives cannot be validated by their social recipients.[118] As I have already established, the perceived 'incomprehensibility' of such texts has already been constructed as a symptom by psychiatry. Authentic yet unorthodox narratives are permitted to reflect only the 'otherness' of 'madness'. Society has been informed that 'madness' deviates from

[116]Mikhail Bakhtin, quoted in Ochs, 'Narrating the Self', p. 31. Italics added for emphasis.
[117] 'Schizophrenese', in brief, is defined by Roy Wolcott as a 'private language' used to communicate an experience of 'schizophrenia', characterised by use of self-created words. See Wolcott, 'Schizophrenese', p. 127. For more information on postmodern narratives and the interplay between self, representation and communication, see Crawford, *Communicating Care*, pp. 5-9.
[118] Cross, *Mediating Madness*, p. 29.

conventional models of communication, and that this is a 'symptom' rather than a desperate attempt to be heard.

Unorthodox narrative models and language use – necessities in communicating *authentic* 'madness' – do not translate between self and society. These 'madness' narratives successfully communicate the self through a process of linguistic realisation. Although these narratives depict 'madness' as a lived and personal experience rather than a psychiatric entity, they are unfamiliar and thus invalidated by their social audience. The narrative process remains incomplete.

Experience Versus Expectation: Deconstructing Paratexts

In addition to the struggle between authenticity and accessibility, 'madness' narratives also expose a conflict between expectation and experience. As Ochs and Capps observed, 'the struggle to reconcile expectation with experience is particularly salient in the narratives of sufferers of mental and physical illness'.[119] This is, again, a war which began with language. Psychiatric discourse – the 'authority' on 'madness' – has informed society that 'madness' is a 'closed' text: any attempts on the part of the 'mad' individual 'to speak authoritatively about their experiences are undermined by the predominant public perception of them as "unreliable" witnesses, subject to hallucinations, delusions and violent tendencies'.[120] Our expectations (that a 'mad' narrator is an 'unreliable' one) impact on how we interpret the experience (a 'madness' narrative).

Psychiatry has established how society views 'madness'. We have preconceived notions and assumptions about what the 'madness' experience is, and these expectations are superimposed onto 'madness' narratives. Psychiatric discourse is, in a sense, the *paratext*, the

[119] Ochs, 'Narrating the Self', p. 29.
[120] Cross, *Mediating Madness*, p. 33.

'material that lies somehow on the threshold of the narrative'.[121] It is the lens through which we interpret 'madness' narratives. I have established the narrative process as a pure state but, in reality, these accounts exist in correlation with other narratives, as part of a wider social context. Any form of narrative framing – albeit literal or something more abstract – has an inevitable influence on how we receive the text. These paratexts 'play critically important roles in the interpretation of the narratives they frame'.[122] Paratexts lie on the 'fringe of the printed text [and] in reality [they] control […] one's whole reading'.[123]

An example of the conflict between experience and expectation – and the integral role played by paratexts – can be found in *The Maniac; A Realistic Study of Madness from the Maniac's Point of View* by E. Thelmar (1909) – an autobiographical account of a journalist's experience of 'madness'. Immediately, the title informs the reader that the narrator is a 'maniac'. Psychiatric discourse has already shaped society's response to this: 'from a mainstream psychiatric perspective, attending or listening to the voice of the mad is pointless since, by the virtue of their unreason, their views are worthless'.[124] In a psychiatric context, 'mania' is characterised by 'grandiose delusions', thus the 'maniac' is hardly depicted as a reliable narrator.[125] The *OED* defines 'mania' as 'madness, particularly of a kind characterized by uncontrolled, excited, or aggressive behaviour': it is typified by excess and extremes which render the 'maniac' 'other'.[126]

The first of four prefaces to Thelmar's narrative establishes a sense of context: '[t]his true record to my doctor, at whose instigation it was written and to whom it was promised'.[127] This paratext suggests to the reader that the text was produced at the specific request of

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[121] Porter Abbott, *Introduction to Narrative*, p. 25.
[122] Ibid.
[123] Genette, *Paratexts*, p. 2.
[124] Cross, *Mediating Madness*, p. 25.
[125] Semple, *Handbook*, p. 95.
[126] *OED*, 'mania' <http://www.oed.com/view/Entry/113459?rskey=BIcqu4&result=1#eid> [accessed 11 Feb 2013].
[127] E. Thelmar, *The Maniac; A Realistic Study of Madness From the Maniac's Point of View* (London: Rebman Limited, 1909), p. *v.*

someone in the psychiatric profession. Here, psychiatric 'authority' imposes itself on the reading in a more literal sense: psychiatry is identified as the intended audience. This initial preface depicts Thelmar's narrative as part of a conversation between 'patient' and psychiatrist, a dynamic that further reinforces the belief that a 'madness' narrative has little worth other than as a tool for psychiatry to interpret as a series of symptoms.

The reader then encounters a 'Publishers' Note' which reads:

> The Publishers are perfectly satisfied that this book is a genuine record of a case of madness from the patient's point of view, and therefore have no hesitation in recommending it as a most valuable psychological study to all interested in such subjects, and especially to members of the medical profession. To the General Public it is offered as the most weirdly sensational of novels.[128]

The voice of the publisher attests that the narrative is the product of a *genuine* 'maniac', attempting to confirm the authenticity of Thelmar's 'madness'. The reader is given insight into the perceived worth of the document. Instead of viewing this narrative as something which speaks of 'real collective social experience', or even as a vitally important narrative used to reclaim and reconfigure the self after a traumatic experience of illness, the 'Publishers' Note' diminishes its worth to that of a 'psychological study' for the medical profession.[129] It may have significance only as a psychiatric case study. The 'General Public' are invited to view the narrative as 'the most weirdly sensational of novels'.[130] This statement trivialises the 'madness' experience, reducing it to a curiosity, a form of entertainment. Echoing Bethlem hospital staff 'seiz[ing] a marketing opportunity by allowing the paying public entry to the hospital to view the inmates', 'madness' is depicted as a spectacle at the expense of Thelmar's humanity.[131]

Finally, the reader encounters a foreword by the author. The self behind the 'most weirdly sensational of novels' emerges to declare her narrative 'a faithful account of a

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[128] Thelmar, *Maniac*, p. *viii.*
[129] Cooper, *Language of Madness*, p. 22.
[130] See chapter three for a more detailed discussion of the relationship between the Sensation genre and 'madness'.
[131] Cross, *Mediating Madness*, p. 49.

genuine attack of Acute Mania'.[132] This demonstrates the struggle of the individual to declare the authenticity and worth of her narrative to its intended audience:

> Nothing has been invented – from first to last this is a true record […and] remembrance of [the 'manic' episode] as vivid as the actual time of its occurrence […] to transcribe the entire account, verbatim, has been but the smallest effort of memory on my part.[133]

This foreword embodies the conflict between experience and expectation. For Thelmar to have felt the need defensively to declare her account 'true', there must have been an assumption that this would be disputed. The narrator anticipated that psychiatric discourse had established her as 'unreliable', hence her struggle to emphasise the *accuracy* of her own account. To borrow a term from narrative theory, this foreword also exposes the social tendency to construct an 'implied author': 'the mental picture of the author that a reader constructs on the basis of the text in its entirety'. [134] However, considering the psychiatric and social conviction that the 'mad' author is unreliable, it appears that the implied author can be superimposed onto a narrative even before the text is opened. When one approaches Thelmar's narrative, one is able to discern from the title alone that this is a 'madness' narrative. The reader immediately develops expectations – informed by, among other things, psychiatric discourse – of who the author is, how she will behave, and, ultimately, whether or not the text is worthy of validation.

As I establish in chapter two, the construct of the 'mad', unreliable narrator is a common feature in psychiatric texts. By depicting those labelled 'mad' as unable to communicate their experiences accurately or coherently, psychiatry rules supreme as the 'authority' on talking about 'madness' because of its ability to 'estrange and muffle alternate

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[132] Thelmar, *Maniac*, p. *ix*.
[133] Ibid.
[134] Michael Toolan, *Narrative: A Critical Linguistic Introduction* (London: Routledge, 2001), p. 65. I am using the terms narrator and author interchangeably here, in the context of *The Maniac*: due to the autobiographical nature of the text, the author and the narrator function as a single entity.

perspectives'.[135] Psychiatrist Bruce Cohen argued that 'user stories are disempowered by contact with mental health professionals', but there does not even have to be any direct engagement between these narratives: psychiatry has already informed the way that society responds to and interprets the 'madness' experience.[136] In the case of any 'madness' narrative, the *implied* author is an *unreliable* one.

To return, briefly, to *The Maniac*, the author's foreword directly challenges psychiatric 'authority', declaring:

> [T]he most highly-trained 'mental' doctors and nurses are, evidently, most utterly at sea with regard to a lunatic's *Consciousness*. The location, the extent, and, above all, the *limitations* of a mad patient's consciousness are so wholly misjudged and misapprehended. That this is so, is indubitably proved to any one [*sic*] who has experienced madness – and will be apparent to any one [*sic*] who reads this narrative […] Perhaps some of them may even manage to learn something from this 'Human Document'.[137]

This emotive bid for narrative power stands in contrast to previous paratexts which trivialised and dismissed Thelmar's narrative. Her wish that her narrative be read as a 'Human Document' has already been destabilised by the 'Publishers' Note'; any member of the 'General Public' who encounters this text is first confronted with the 'Publishers' Note', which insists they interpret this narrative as a form of cheap entertainment, 'the most weirdly sensational of novels'.[138] By the time they are confronted with Thelmar's plea that her text is to be read as a 'Human Document', the 'Publishers' Note' has usurped Thelmar's position as the authority on her own experiences. The assumption of Thelmar's unreliability means that the reader relies on the presence of other narrators – in this case, the 'Publisher' – as a mediating force, as a translator, and as a way of contextualising the narrative as a whole.

Thelmar's narrative is the perfect example of how narrative framing can distort an interpretation of a text: it is yet another contributing factor to what Freud termed the 'failure

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[135] Ochs, 'Narrating the Self', p. 33.
[136] Bruce M. Z. Cohen, *Mental Health User Narratives* (Hampshire: Palgrave MacMillan, 2008), p. 41.
[137] Thelmar, *Maniac*, p. *x*. Emphasis in original.
[138] Thelmar, *Maniac*, p. *viii.*

of translation' which reinforces the social positioning of the 'mad' as 'other'.[139] Narrative worth is judged in relation to 'how people construct and use the text to generate particular meanings in specific contexts, and [how] significant others interpret and react to the message they receive'.[140] Narrative tensions in *The Maniac* shape the social reception of the 'madness' narrative which exists at the core of the text. Paratexts act as yet another obstacle which prevents lived experience of 'madness' from being heard. As with taxonomy, these narratives are burdened with the weight of psychiatric and social (mis)conceptions and stereotypes. The *expectation* that Thelmar – as a 'maniac' – is unable to narrate accurately and coherently clashes with Thelmar's *experience* that her account is written 'with as exact verbal accuracy as if they had been taken down by shorthand reporter at the time they were being uttered'.[141]

It can be easy to overlook the cost of such politics. If the 'mad' self attempts to provide a counter-narrative to hegemonic discourse, 'the unbearable identity of the narrator and of the surroundings that are supposed to sustain him can no longer be *narrated*'.[142] When it comes to narrating 'madness', there is always the very real risk that such narratives will result in 'either stigma or social death'.[143] The possibility of social engagement (of a *validated* narrative) also presents the potential for further social alienation (a *disregarded* narrative). To reveal a vulnerable or fragile self to the world is, inevitably, to be laid bare: such 'open communication is often thought of as obscene self-exposure'.[144] As Laing invited us to 'be more frank about the judgements we implicitly make when we call someone psychotic', it is essential that, when discussing the issues latent in talking about 'madness',

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[139] Freud, *Complete Letters*, p. 208.
[140] Migliore, 'Illness Narratives', p. 102.
[141] Thelmar, *Maniac*, p. *ix*. A contrast can be found when Freud conceded that his reconstruction of 'patient' narratives was 'not absolutely – phonographically – correct'. Our *expectation* of psychiatric 'authority' means that we are unlikely to challenge Freud's apparent expertise. By contrast, because of her 'madness', Thelmar has to defend her ability to narrate accurately. See Sigmund Freud, *Case Histories I*, trans. by James Strachey, ed. by Angela Richards and Alan Tyson (Harmondsworth: Penguin, 1977), p. 38.
[142] Julia Kristeva, *Powers of Horror: An Essay on Abjection*, trans. by Leon S. Roudiez (New York: Columbia University Press, 1982), p. 141. Emphasis in original.
[143] Kleinman, *Illness Narratives*, p. 26.
[144] Rolf Breuer, 'Irony, Literature and Schizophrenia', *Psychology and Literature: Some Contemporary Directions*, 1 (1980), 107-18 (p. 110).

we do not lose sight of the devastating impact these language problems have on the individual labelled 'mad'.[145]

The Language of 'Madness': A Person-Centred Approach

This chapter has established how the language of 'madness' became burdened with stigma, and how narrative and semantic politics came to prevent 'madness' narratives from entering the vernacular, to challenge the 'authority' of hegemonic discourse. The rest of this thesis places the theoretical approach I have outlined into context. I explore *how* these established narrative and language politics directly interfere with the communication of a personal experience of 'madness'. The theoretical ground I have covered in this chapter is the foundation: as the following chapters demonstrate, my primary concern is with the status of the individual narrative. Thus, I switch from a theoretical to a person-centred approach, in order to establish the reality of narrating when language is burdened with expectation and stigma.

This theoretical underpinning does suggest potential ways – if not possible solutions – in which the damage caused by language can be reduced. One must consider the binary opposition of 'insanity' and 'sanity'. Saussure, for example, emphasised the 'linear character of language'.[146] He argued that 'one must allow for a faculty of association and coordination which comes into operation as soon as one goes beyond individual signs in isolation'.[147] When language functions as a system (*langue*), the relationship between the signifier and signified also accommodates 'association and coordination'. The psychological imprint left by a signified is, in part, constructed using binary oppositions: much as we comprehend 'dark' as an absence of 'light', so we understand 'insanity' in relation to 'sanity'. Society

[145] Laing, *Divided*, p. 27.
[146] Saussure, *General Linguistics*, p. 121.
[147] Saussure, *General Linguistics*, p. 13.

perceives ‘sanity’ as rational and coherent, thus ‘insanity’ is seen to be a deviation from this established ‘norm’.[148]

Laing argued that the established ‘sane’/‘insane’ binary (with its concomitant assumption that ‘sanity’ is the ‘norm’) is responsible for the alienation of the ‘mad’ from mainstream society:

> *Sanity or psychosis is tested by the degree of conjunction or disjunction between two persons where the one is sane by common consent* […] The ‘psychotic’ is the name we have for the other person in a disjunctive relationship of a particular kind. It is only because of this interpersonal disjunction that we start to examine his urine, and look for anomalies in the graphs of the electrical activity in his brain.[149]

‘Madness’ is judged by how it differs from ‘sanity’, and ‘sanity’ is demonstrated by the absence of ‘madness’: each side of the binary opposition stabilises the other. It is divergence from ‘sanity’ which society uses as justification for objectification (the transformation into a medical spectacle) and for alienation (to be ‘mad’ is to be one of *them* – an ‘other’ – rather than one of ‘us’). However, mainstream society is only ‘sane’ by ‘common consent’.[150] Indeed, the concept of ‘sanity’ is nothing more than a collective assumption. The binary of ‘sanity’/‘insanity’ appears fragile, and yet it is fundamental to the status quo, the ‘us’-versus-‘them’ mentality which ‘others’ ‘madness’. Laing elaborated that the ‘sane’/‘insane’ opposition enforces silence: ‘madness’ ‘must remain incomprehensible to us. As long as we are sane and he [the “madman”] is insane, it will remain so’.[151]

Saussure was resolute that ‘a linguistic revolution is impossible’, that neither an individual nor society could consciously alter the process of signification.[152] However, if society cannot amend the relationship between a signifier and a signified, could the

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[148] The *OED* lists the definition of ‘sane’ as ‘*not mad* […] sensible, rational’. See *OED*, ‘sane’ <http://www.oed.com/view/Entry/170606?rskey=47nr9o&result=1&isAdvanced=false#eid> [accessed 24 September 2015].
[149] Laing, *Divided*, p. 36. Emphasis in original.
[150] This idea of ‘common consent’ significantly overlaps with Saussure’s concept of the *langue*: we, in our Anglophone culture, consent to the signifier ‘c-h-a-i-r’ referring to a piece of furniture. However, our French counterparts have consented to using the signifier ‘c-h-a-i-r’ to signify a slab of meat.
[151] Laing, *Divided*, p. 38.
[152] Saussure, *General Linguistics*, p. 74.

'association[s] and coordination[s]' attached to signification be revised instead?[153] If our perception of 'sane' is altered or distorted, our understanding of 'madness' is transformed alongside it. If our idea of 'sanity' becomes fluid (as opposed to an absolute, fixed concept, as the 'norm'), then there is potential for the binary opposition of 'sane'/'insane' to be seen as a spectrum rather than a dichotomy.[154] This negation allows for the possibility of 'madness' to be coaxed out of social exile, back into the realm of shared discourse as an experience which is a variant of 'sanity', rather than as an experience which stands in opposition to it. In order for 'madness' to be something other than 'other', we need to challenge the structures which have depicted 'madness' as an alien experience rather than a *human* one.

[153] Saussure, *General Linguistics*, p. 13.

[154] As I discuss in my conclusion, in gender research, spectra and fluidity have overwritten the orthodox dichotomy of 'masculine' and 'feminine'. This rejection of binaries is, gradually, influencing the way gender is represented and perceived in popular culture. A homologous model for thinking about 'madness' – which presents 'sanity'/'insanity' as a spectrum – is equally viable.

CHAPTER TWO

‘Plundered, Organised and Published’: Constructing the Self under the Psychiatrist’s Gaze[1]

In psychiatric narratives, the relationship between the ‘patient’ and language is used to judge the extent of ‘illness’, and how viable ‘recovery’ might be.[2] Throughout Kraepelin’s *Lectures on Clinical Psychiatry*, for example, the language of the ‘patient’ is deemed a clear indication of whether or not ‘cure’ is, indeed, possible.[3] Kraepelin reflected on the case of one ‘patient’ who, despite ‘generally keep[ing] quite quiet’, conversed through a ‘shower of delusionary talk’, becoming increasingly ‘incoherent and irritated’.[4] Despite the ‘patient’ only being incarcerated for three months at the time of writing, Kraepelin concluded: ‘I may say from experience that such cases usually present almost exactly the same features for dozens of years, and neither recover nor become more mentally dull’.[5]

By contrast, Kraepelin described a case whereby a ‘patient’, experiencing hallucinations, ‘improved quickly’ after a brief period under the psychiatrist’s jurisdiction.[6] Kraepelin explained that this improvement was evident not only when the hallucinations ceased, but when the ‘patient’ ‘took a *correct* view of those he had previously seen’ – in other words, when the ‘patient’ had acceded to the psychiatrist’s discourse, and was thus able to

[1] Kraepelin, *Dementia Praecox*, p. 12.
[2] According to Hegel, ‘cure must be sought in the reexternalization (rebirth) of the self into relations with others *through a path back to language*’. See Berthold, ‘Talking Cures’, p. 306. Italics added for emphasis.
[3] The concept of ‘cure’ needs to be challenged, or at least complicated. After all, if an acceptance of psychiatric language indicates ‘cure’, what about the later examples I discuss whereby this vocabulary is merely ventriloquised? Kraepelin described ‘a complete cure’ as a state whereby ‘the symptoms which [were] so urgent and important […] disappear entirely’ (see Kraepelin, *Lectures*, p. 268). However, this is very problematic, particularly considering that, in the context of a psychiatric text, there may be a disconnect between that which a ‘patient’ considers a ‘symptom’, and psychiatric interpretation. Similarly there may be a clash between personal and psychiatric understandings of being ‘symptom-free’. The idea of ‘cure’ is also further complicated by how many of the case study narratives are left unresolved, without information of how the ‘patient’s’ story ends: is this aporia resolved with an assumption of ‘cure’, or ‘relapse’?
[4] Kraepelin, *Lectures*, p. 156.
[5] Ibid.
[6] Kraepelin, *Lectures*, p. 188.

'recognise' and communicate his previous experience of 'reality' as an hallucination.[7] The 'patient's' 'good insight into his malady' had transformed him: Kraepelin observed that 'there is nothing at this moment to remind us of the illness he has been through'.[8] By accepting hegemonic language and psychiatric 'authority', the 'patient' was restored to 'sanity', unlike Kraepelin's previous 'patient', whose recalcitrantly 'delusionary' language had denied him the same possibility of 'cure'.

A return to 'sanity' is exhibited by an acquisition of 'self-awareness, self-control, autonomy and recuperation', signified by a return to conventional language: finding 'the words to say it'.[9] If 'madness' is 'a kind of non-knowledge' defined as 'a deviation from a process of the genesis of knowledge', then 'sanity' can be characterised as a return to 'reason'.[10] Once the 'mad' individual (re)acquires conventional language – the *nom du père* – they are accepting hegemonic narratives of how their experiences should be configured. The individual must surrender their personal narrative and formulate it using the terminology which identified it as a 'madness' narrative in the first place, allowing it to merge with and, ultimately, ratify the power of the governing discourse. In the case of 'madness', this dominant narrative is the language of psychiatry. An inability or refusal to internalise psychiatric discourse is to display what Bleuler termed 'insufficient insight': a state which condemns the 'patient' to a 'revolving door' relationship with the asylum, and a perpetual and encompassing state of 'madness' and 'otherness'.[11]

Academic and writer James Phillips contended that, for prominent psychiatrists and psychoanalysts such as Freud and Lacan, 'the state of reason is the state of language, and

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[7] Ibid. Italics added for emphasis.
[8] Kraepelin, *Lectures*, p. 188. Here, the politics of performative obedience echo Laing: 'I must play their game, of not seeing I see the game'. See R. D. Laing, *Knots* (New York: Random House, 1970), p. 1.
[9] Roy Porter, *The Faber Book of Madness* (London: Faber and Faber, 1991), p. 519.
[10] Cutler, 'Philosophical Coquetry', p. 93.
[11] Eugen Bleuler, *Textbook of Psychiatry*, trans. by A. A. Brill (New York: Macmillan and Company, 1924), p. 353. Thus, paradoxically, the 'patient' exhibits 'insight' by accepting they *lack* 'insight'. In chapter five, I discuss twenty-first-century usage of the term 'insight' in the mental health system, and how it perpetuates the assumption that 'madness' cannot recognise and manage itself.

madness is associated with failures of development in which the self is not formed through language and otherness'.[12] If an experience of 'madness' is not constructed using designated psychiatric vocabulary – language which 'others' 'madness' – this denotes a 'failure' of communication, and a failure of the 'patient' to submit to psychiatric 'authority'.[13] Once the individual internalises this 'otherness', and echoes the language associated with it, they are able to submit to the 'patient'/psychiatrist power dynamic.[14] There is a necessary surrender here. As established in chapter one, this assumption of the 'patient' role denotes the individual as 'unreliable': their command over their own experiences is usurped, their voice is 'plundered, organised, and published' by psychiatric discourse.[15] The individual voice – which embodied the potential to offer a counter-narrative, which questions and challenges the assumption that psychiatry is the 'authority' on 'madness' – is consumed by psychiatric narratives which reconstruct it.

In chapter one, I used the example of Thelmar's 'madness' narrative to demonstrate the impact the psychiatric presence has on the reading experience, particularly in how readers are encouraged to respond to a 'mad' narrator. However, far from being unique to this text, the narrative politics which prevented mainstream society from accessing and empathising with Thelmar's experience are indicative of a much wider issue. Psychiatric narratives have muffled, and continue to muffle, and devalue, the individual experience of 'madness'. This legacy of institutional silencing must have begun somewhere, so this chapter explores the

[12] James Phillips, 'Madness of the Philosophers, Madness of the Clinic' *Philosophy, Psychiatry and Psychology*, 4 (2009), 313-17 (p. 315).
[13] As I established in chapter one, an account of 'madness' constructed beyond psychiatric vocabulary is not recognised and thus validated by a social audience, therefore the narrative process remains incomplete, and communication fails.
[14] This surrender can be performative – an *illusion* of obedience – as I demonstrate shortly. However, to accept and echo psychiatric discourse, even superficially, is to gratify and strengthen the 'authority' of this hegemonic discourse. An acceptance of the 'patient'/psychiatrist power dynamic perpetuates the myth that 'madness' requires psychiatric governance, which I explore further in chapter five.
[15] Kraepelin, *Dementia Praecox*, p. 12.

genesis of the overlap between 'madness' narratives and psychiatric narratives, to understand the disenfranchisement at the centre of the 'patient'/psychiatrist dynamic.[16]

The primary focus of this chapter is to retrieve individual experiences from under layers of hegemonic discourse.[17] When I use the term 'case study narratives', I am referring to any narratives salvaged from contact with psychiatry: such texts usually appear in the context of psychiatric publications, although not exclusively. My primary focus consists of case studies from the birth of psychiatry, as the majority of the terminology available for discussing and 'othering' 'madness' has its origins in the late-nineteenth and early-twentieth centuries. As this vocabulary has had such a prevailing influence on how we (mis)communicate and (mis)understand 'madness' in our modern social context, I explore how this language is used by psychiatrists, what it signifies and, ultimately, the impact that it has had (and still has) on the articulation of lived experience.

By reclaiming personal voices from the publications of renowned Western psychiatrists, such as Freud, Bleuler and Kraepelin, I dismantle and challenge this medicalised context. I also explore the conflict between personal experience and psychiatric expectation in nineteenth-century 'madness' memoirs, such as 'A Sane Patient's' *My Experience in a Lunatic Asylum* and John T. Perceval's *Perceval's Narrative: A Patient's Account of his Psychosis.*[18] These texts are used to examine the relationship between the 'mad' self and language in a psychiatric context, as revealed through use of conventional discourse, unorthodox narratives or through an absence of engagement (signified by silence).

[16] The interplay between 'madness' as a personal experience and 'madness' as a pathologised phenomenon inevitably began with the birth of psychiatry, hence the nineteenth- and early-twentieth-century focus of this chapter.
[17] 'Authenticity' is a term I explored in-depth in chapter one: in this instance, I am referring to a narrative *of* 'madness' (lived experience) rather than a narrative *about* it (psychiatric discourse).
[18] In order to be consistent in addressing texts which fit in this medicalised context, my chief criterion for selecting memoirs is that the author of such texts has had contact with psychiatry, and thus has been rendered into, or has resisted, the role of 'patient'.

This chapter begins by critiquing narrative framing: breaking down the paratexts of case study narratives in order to understand how they are used to create an implied, unreliable narrator. The language used to anticipate such case studies is examined alongside the voice of the 'patient': how are our expectations established? How are we encouraged to respond to these narratives? This presence of the psychiatric gaze manipulates how the reader receives individual narratives in this psychiatric context.[19] My primary concern throughout this chapter is how this affects the narrative process: how does this framing distort what was initially a three-stage process? How does it impact on the individual trying to configure a sense of self through language? How does it alter the way in which the narrative is received – a process necessary for the 'patient' to salvage a sense of self from a traumatic, devastating ordeal of illness? I also scrutinise the dual role of the psychiatrist/editor and establish how the politics of language and discourse are inevitably linked to power dynamics. To have a mastery of language is to have the privilege of voice, and dominion over disenfranchised narratives: if one's language has neither relevance nor purchase, one is reduced to a position of silence and of passivity, either reluctantly or voluntarily.

Freud, in particular, has been criticised for taking liberties with the voices of his 'patients', for 'edit[ing] or construct[ing]' narratives.[20] He admitted only to offering 'fragmentary extracts': voices edited and recontextualised, stories retold in an 'imperfect and incomplete' fashion.[21] Similarly, a 'patient' being observed by Kraepelin complained about having his narrative 'plundered, organised and published', reframed in a medicalised context

[19] My use of the term 'psychiatric gaze' is based on feminist Laura Mulvey's definition of the 'male gaze'. Mulvey describes a 'split between active/male and passive/female. The determining male gaze projects its fantasy onto the female figure, which is styled accordingly' (Laura Mulvey, 'Visual Pleasure and Narrative Cinema', in *Visual and Other Pleasures: Language, Discourses, Society*, ed. by Stephen Heath, Colin MacCabe and Denise Riley (London: Palgrave, 1989), pp. 14-27 (p. 19)). This passage could, with a few minor alternations, perfectly express the politics of the 'patient'/psychiatrist dynamic. Consider the 'split between active/psychiatrist and passive/"patient". The determining psychiatric gaze projects its diagnosis onto the "patient" figure, which is styled accordingly'.

[20] Elaine Showalter, *Hystories* (London: Picador, 1998), p. 84.

[21] Sigmund Freud, *Case Histories II*, trans. by James Strachey, ed. by Angela Richards (Harmondsworth: Penguin, 1979), p. 36.

which entirely undermined his ability to speak authoritatively of his own experiences.[22] The psychiatrist occupies a reinforced position of power: enforcer of the *nom du père*, editor and translator. How have these dynamics served to establish psychiatry as the 'authority' on 'madness', and simultaneously to allow psychiatric forces to sabotage any potential meaningful engagement between 'madness' narratives and social audience?

The case study narrative context is often complicated by the presence of a translator as the text moves from one language to another: the 'mad' voice becomes increasingly remote from the social audience it is trying to engage. Instead of following the traditional tripartite model of a narrative which I have already established (an articulation of the self; communicated via a narrative; delivered to a social audience), this process becomes disjointed. In its place, there is a convoluted procedure: an articulation of the self, communicated via a narrative, confined in and limited by the wider paratext of a psychiatric document, then translated from one language to another.[23] *You* are then receiving these voices through *my* narrative, although I claim to have taken care not to 'edit' such case studies.[24] The 'mad' voice is kept distanced from the reader, obstructed and oppressed by these narrative layers. Empathy is impossible; the psychiatric paratext has already omitted the possibility of any connection between 'mad' narrative and social audience.

This chapter then explores the language used to construct 'madness' narratives, in order to investigate the relationship these narratives have with semantics, particularly the connection between the 'mad' self and psychiatric vocabulary, imposed during psychiatric intervention.[25] The 'patient' is given language – albeit problematic language – by the

[22] Kraepelin, *Dementia Praecox*, p. 12.
[23] In chapter four, I discuss an equally convoluted narrative process which interferes with the relationship between 'mad' visual art and social audience.
[24] Occasionally, ellipses are a necessary evil, for the sake of concision.
[25] In this nineteenth-century context, 'psychiatric intervention', for the most part, consisted of admittance into an asylum, or, for those wealthy enough to confine their 'mad' relatives at home, into a pseudo-asylum space. For more on the reality of receiving psychiatric 'treatment' in the nineteenth century, see Sarah Wise, *Inconvenient People: Lunacy, Liberty and the Mad-Doctors in Victorian England* (London: Random House, 2013).

psychiatric presence to articulate their alleged ailment: will they adopt it? What happens when the individual accepts, or at least mirrors, this medical terminology? What impact does this have on the 'mad' individual's ability to narrate their experiences and communicate their sense of self? By exploring narratives which are, at least partly, constructed using psychiatric discourse, I examine how these narratives are interpreted, both in the psychiatric framing, and how readers are encouraged to respond to these voices.

As established in chapter one, if an individual wants their experience of 'madness' to be socially heeded (fundamental to the process of narration and, ostensibly, to 'healing') the only current option available is to formulate the experience using known terms: limited and limiting psychiatric discourse. This language does communicate 'madness' in a way which is socially familiar and thus the 'mad' voice is able to enter collective social discourse, albeit as the 'other'.[26] An acquisition, and *imitation*, of the terminology which was used to categorise, label and incarcerate, signifies the 'patient' taking a 'path back to language', a process apparently necessary for 'cure'.[27]

By contrast, I examine narratives which transcend or reject psychiatric terminology. Experiences of 'madness' which are articulated using unconventional language will be explored as an alternative to constructing the self using damaging psychiatric vocabulary. By observing these narratives in their psychiatric context, I establish how the ever-present voice of the alienist serves to influence our reading and undermine the voice of our narrator, declaring such narratives 'peculiar, distorted turns of speech – senseless playing with syllables and words'.[28] As discussed in chapter one, an authentic expression of 'madness'

[26] This is similar to the liminal social role occupied by the Outsider Artist who is simultaneously 'other' but also an 'artist' (and thus granted a narrative platform and a 'movement'). I discuss this in detail in chapter four.
[27] Berthold, 'Talking Cures' p. 306.
[28] Kraepelin, *Lectures*, p. 24. 'Alienist' was a nineteenth-century term used to describe a psychiatrist, rooted in the assumption that 'madness' was an 'alien' state: the suffix 'ist' denotes 'a votary of, or expert in' therefore the psychiatrist is considered to be the 'authority' on managing the 'alien' 'mad' (see *OED*, 'ist' <http://www.oed.com/view/Entry/100221?rskey=ZRo7bk&result=1&isAdvanced=false#eid> [accessed 29 January 2016].

requires a rejection, or transcendence, of hegemonic narratives, to avoid personal experience being censored by the 'otherness' latent in psychiatric discourse. However, this is done at the expense of social validation, as such narratives represent 'madness' in unfamiliar terms. What can be salvaged from a narrative which *truly* articulates what it means to experience 'madness', expressed without the language of 'otherness', and yet which cannot be socially received because the psychiatrist, always over the shoulder of the reader, has already disregarded and dismissed such a text?

Bleuler conceded that unconventional language has a place in 'madness' narratives, explaining that, as 'patients' experience 'things which are unknown to normal persons […] the patient must create new concepts'.[29] However, when the 'patient' transcends orthodox language, their voice is diminished and devalued, described as 'nonsense', 'gibberish' and made up of 'empty speech acts'.[30] Despite Bleuler acknowledging the need for 'new concepts' and neologisms, any attempts made by the individual to configure the self in terms other than the language of psychiatry are disregarded as 'silly plays on words'.[31] How does this relationship with language influence the delivery of these narratives to their intended reader? If a personal account of 'madness' is perceived as something *silly*, as '*wholly incomprehensible gibberish*'[32], as what Lacan termed 'non-knowledge', then 'attending or listening to the voice of the mad is pointless since […] their views are worthless'.[33]

My first chapter established an enduring 'language problem' when it comes to communicating 'madness', and most of this second chapter will be dedicated to this struggle to understand and articulate the self through language in its various forms. However, I also explore instances of silence, a complete refusal to engage with language that has the potential

[29] Bleuler, *Textbook*, p. 70.
[30] Lovell, 'City is My Mother', p. 356.
[31] Kraepelin, *Dementia Praecox*, p. 68.
[32] Ibid.
[33] Allan Ingram and Michelle Faubert, *Cultural Constructions of Madness in Eighteenth-Century Writing* (Hampshire: Palgrave Macmillan, 2005), p. 25.

to fracture the 'patient'/psychiatrist relationship. If one refuses to articulate an experience of 'madness', one is, to an extent, beyond the realms of scrutiny: the silent individual does not enter the realm of self-exposure necessary for the role of 'patient'. Silence can be interpreted as passivity, an absence of protest, and a reluctance to enter communal discourse but it is also a mute form of power. By not using language, one is unable to configure a sense of self, as 'to be a human self is to be a linguistic self': to be a narrated self is to be a social self.[34] However, the silent individual is also denying the psychiatrist command over their (the 'patient's') identity: without self-exposure, there is no narrative for the psychiatrist to construct or edit, no use of unorthodox language to condemn, no exchange through which the process of diagnosis can take place. Labels may be applied, but the 'patient' neither confirms nor refuses taxonomy.

The psychiatrist's 'authority' is based on a mastery of language, but silence removes the psychiatrist/'patient' dynamic from the realm of the written and the verbal. However, this is at the expense of an individual narrative and, ultimately, selfhood. I examine instances of silence in order to establish how mute narratives are received, with a particular focus on the relationship between narrative and readership. How does psychiatric framing encourage us to respond to such 'non-narratives'? Is silence the only available option for liberating the inherent ineffability of an experience of 'madness' from the language of psychiatry which seeks to reduce it?

'I Cannot Give a Complete History': Deconstructing Narrative Framing[35]

The politics of narrative framing are pervasive, and are apparent in many forms. The initial, and perhaps most fundamental, conflict which obstructs the relationship between narrator and potential social audience is that 'madness' narratives are a battleground for the struggle of

[34] Berthold, 'Talking Cures', p. 306.
[35] Freud, *Case Studies II*, p. 36.

experience versus expectation, as established in chapter one. The expectations we bring to a narrative, as shaped by hegemonic discourse, function as paratexts. This framing has an inevitable influence on how a narrative is interpreted: it 'play[s a] critically important role'.[36]

In the context of the case study, these narrative layers become even more influential, and take on literal forms: prior to receiving a 'madness' narrative, we have a psychiatric presence which informs us of the 'patient's' diagnosis, and apparent anomalies. This reinforces our assumptions: we understand we are about to encounter the voice of a 'mad' 'patient' and we are guided by the dual 'authority' of the psychiatrist/editor. Lord Shaftesbury, appointed Chair of the Lunacy Commission in 1827, acknowledged the impact of such expectations:

> What an awful condition that of a lunatic! His words are generally disbelieved, and his most innocent peculiarities perverted […] We know him to be insane; at least, we are told that he is so; and we place ourselves on guard – that is, we give to every word, look, gesture a value and a meaning which oftentimes it cannot bear, and which it would never bear in ordinary life.[37]

We are told that the 'patient' is 'insane' by the assumed power of the psychiatrist. Because of this, 'every word' becomes significant – it becomes a symptom – but the self cannot bear the burden of such scrutiny, as 'the unbearable identity of the narrator […] can no longer be *narrated*'.[38] Under the psychiatrist's dissecting gaze, the 'mad' individual no longer has the right to a stream of consciousness, a flight of ideas, or indeed any sort of 'incoherent thought', despite these being fundamental to any interior monologue. These thoughts or ideas, framed by a psychiatric context, become 'riddles unanswered […] totally obscure and unilluminated'; symptoms of a mind in a state of disorder.[39] In what Shaftesbury termed 'ordinary life', these internal processes would collapse under such constant interrogation,

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[36] Porter Abbott, *Introduction to Narrative*, p. 25.
[37] Lord Shaftesbury, *Diaries*, 18 November 1844, in Andrew Scull, *The Insanity of Place/The Place of Insanity: Essays on the History of Psychiatry* (Oxon: Routledge, 2006), p. 63.
[38] Kristeva, *Powers*, p. 141. Emphasis in original.
[39] Freud, *Case Histories I*, p. 46.

however, the ‘mad’ subject is perpetually exposed to the ‘awful condition’ of continuous scrutiny.

Paratexts can also expose the complicated politics involved in narrative framing. The purpose of psychiatric publications – to identify and prove symptoms of ‘madness’ – overwhelms the ‘patient’s’ ‘struggle between annihilation and survival to reclaim a sense of self’.[40] The function of the individual ‘madness’ narrative becomes irrelevant, consumed by the motive of the wider psychiatric text.

Freud, for example, notoriously exercised editorial agency on the narratives of his ‘patients’, only using ‘fragmentary extracts’, and transcribing their stories in a manner which he described as ‘not absolutely – phonographically – correct’.[41] Academic and writer Elaine Showalter has criticised Freud for taking such liberties with the narratives of ‘patients’, describing how he ‘fill[ed] gaps in the hysteric’s interpretations, but also […] overc[a]me her resistance to his narrative interpretations. For this therapy to work, the hysteric had to accept and believe the analyst’s story’.[42] This echoes my earlier assertion that ‘sanity’ can only be obtained once hegemonic discourse has been acknowledged and internalised. These politics serve to detach the humanity of the ‘mad’ individual from what should be a personal illness narrative, and confuse what should be an intimate reading process. The reader receiving the text is unable to access the ‘madness’ narrative directly: instead, it is distorted through narrative politics and paratexts. The ‘mad’, unreliable narrator is implied – and disregarded – before their narrative is even encountered.

Genette argued that narrative framing occupies a ‘privileged place of a pragmatics and a strategy, of an influence on the public’.[43] Paratexts represent a conscious process of recontextualisation which may be conducted only by those privileged both with a voice, and

[40] Lovell, ‘City is My Mother’, p. 360.
[41] Freud, *Case Histories I*, p. 38.
[42] Showalter, *Hystories*, p. 85.
[43] Genette, *Paratexts*, p. 2.

with an ability to silence others. Thus, when 'madness' narratives are framed with 'authoritative', 'reliable' accounts of the individual's *unreliability*, the reader assumes the stance of the psychiatrist: objectively scrutinising and seeking anomalies, disengaged from the human context of such narratives. Kraepelin introduced one case study with the almost dismissive declaration that 'they [the "mad" individual] cannot grasp a thought, cannot understand anything: their mind is scattered; their thoughts have flowed away; their brain is no longer competent'.[44] In making this statement, Kraepelin exploited his position of narrative privilege. His analysis, serving as a paratext to the 'madness' narrative, imposes a set of expectations onto the reader. The reader then anticipates a 'scattered' narrative, the product of an 'enfeebled' brain, and even if this clashes with their interpretation, they are often led to invalidate their personal response in favour of Kraepelin's judgement. After all, he still occupies a position of narrative hegemony and represents reason and reliability: the binary opposite of the implied, 'mad' narrator.

Another example of this pervasive expectation can be found in the narrative of 'A Sane Patient' (1879). The identity of the narrator immediately presents a paradox: our narrator accepted the submissive role of 'patient' and yet simultaneously asserted a state of 'sanity'. The pseudonym reveals a liminal identity, caught between an acceptance of psychiatric discourse (that which declared him a 'patient') and insubordination. Having proclaimed a state of 'sanity', the narrator has attempted to configure an identity beyond that of psychiatric subject. However, the title – *My Experiences in a Lunatic Asylum* – undermines this attempt. The phantom of expectation prevails. The reader understands that this 'sane patient' has been incarcerated: whether or not the document is validated now rests on whether the reader accepts the 'patient's' assertions of 'sanity', or the judgement of the psychiatrist

[44] Kraepelin, *Dementia Praecox*, p. 20.

who detained him.[45] Inevitably, psychiatric 'authority' reigns supreme. Without any direct interference from the psychiatrist/editor, the expectations harboured by society, informed by the psychiatric perception of what 'madness' is, act as the paratext here, controlling 'one's whole reading of the text'.[46]

This struggle between experience and expectation is evident throughout *My Experiences in a Lunatic Asylum*. For example, the narrator recounted the words of an alienist: 'you are mad; therefore your words and thoughts are inconsecutive'.[47] The sense of expectation I have already outlined does not only impact on the relationship between reader and narrative: it has ramifications for the individual, too. If the notion that one's thoughts are inconsecutive and incoherent is perpetually echoed by a psychiatrist, and that same voice restricts one's identity to that of 'mad' 'patient', the epitome of unreason, how can it not affect how the individual views and articulates the self? Again, the position of the psychiatrist is paramount here: the expectations of what 'madness' will be struggle against an experience of 'madness'. If a 'patient', on admission to an asylum, is informed by the 'experts' that, as a result of their state of mind, their thoughts will be 'inconsecutive' and disordered, could this become a self-fulfilling prophecy? Would we not *all* find evidence of 'inconsecutive' thoughts in our internal monologue, regardless of our psychiatric history?

Porter argued that 'institutional psychiatry physically isolated the mentally sick from society, and put obstacles in the way of communication'.[48] If an experience of 'madness' cannot reach an audience, then this further affirms the position of the psychiatrist as 'authority' as no counter-narrative exists to challenge this hegemony. An example of such 'obstacles' can be found in Bleuler's *Textbook of Psychiatry*, in which he repeatedly recontextualised the voice of his 'patients' from an attempt at communication, to proof of

[45] By 'validation', I am referring to the final stage of the narrative process, as detailed in chapter one: a narrative requires validation from the intended audience in order for the narrated self to engage with their social context.
[46] Genette, *Paratexts*, p. 2.
[47] 'A Sane Patient', *My Experiences in a Lunatic Asylum* (London: Chatto and Windus, 1879), p. 33.
[48] Porter, *Social History*, p. 32.

'otherness'. By introducing 'patient' narratives as 'gibberish', as *non*-communication, Bleuler clearly dismisses their value. Bleuler shared a fragment of a 'patient's' narrative, which he prefaced with the claim that the passage displays 'a weakness in the patient's reflection and judgement'.[49] The narrative is described as 'inadequate [and] lack[ing] in orderly arrangement'.[50] The 'patient' is portrayed as having an unstable relationship with both language and reason, while the psychiatrist represents a mastery of (and, indeed, a *judge* of) language and the epitome of objectivity and rationality. A lack of 'orderly arrangement' suggests a narrative in chaos: an arbitrary stream of consciousness rather than a form of communication. By denoting the voice of the 'patient' as *non*-communication, Bleuler's narrative (which 'effectively' communicates information) stands in stark contrast to the individual experience of 'madness'.[51] This narrative framing establishes a conflict between successful (the psychiatrist's) and failed communication (the 'patient's') before the reader has even encountered the case study. The reader expects 'narrative coherence' for successful communication, and it is no coincidence that the 'mad' 'patient's' discourse is presented as having none of the consistency and rationality which characterises hegemonic narratives.[52]

Now anticipating that the narrative they are about to encounter exists in opposition to the one which introduced it, the reader finally receives the voice of the 'patient':

> The stimulus word 'key' elicited the following: 'Oh you can have all the keys you want, they broke into the store and found peas, what's the use of keys, policemen, watchman, dogs, dog shows, the spaniel was the best dog this year, he is Spanish you know […] he drowned them all in the bay, gay, New York bay, Broadway, the White Way'.[53]

Bleuler's voice is still present here, reminding us of the psychiatric context of this narrative, informing us that the narrative was generated from a stimulus word, 'key'. Again, expectation

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[49] Bleuler, *Textbook*, p. 73.
[50] Ibid.
[51] Presumably, contributing factors to the 'efficacy' and 'success' of Bleuler's communication include deferential translation and respectful editing, a stark contrast to how Bleuler handled 'patient' narratives.
[52] Genette, *Paratexts*, p. 40.
[53] Bleuler, *Textbook*, p. 73.

triumphs over experience. Use of a stimulus word suggests that the psychiatrist was encouraging a form of word association; such prompts 'were *carefully selected* in order to control for associative response frequencies'.[54] This context warrants different expectations: while the reader would expect some connections to which they could relate, the narrative would appear much like a stream of consciousness. However, this context has not been established in any detail: any reader unfamiliar with the function of a 'stimulus word' assumes that the narrative is just an unprompted outburst from the 'patient'. Bleuler allowed his reader to assume that this narrative is representative of all speech and communication from the 'patient', and thus from anyone who experiences 'madness'. Dear reader, be appreciative that Bleuler, the epitome of reason, master of the *nom du père*, the absolute 'authority' on 'madness', is able to translate and edit the rambling, 'mad' voice for us, and thus maintain a 'safe' distance between society and the incoherent, unpredictable 'other'.

Bleuler's framing did not explain the context which would salvage a seemingly arbitrary narrative from being classified indefinitely as *non*-communication. Perhaps this was simply an assumption on Bleuler's part that we – or his intended audience – would comprehend more than is made explicit. However, an awareness of context does undermine the validity of Bleuler's observations. The stream of consciousness which the psychiatrist prompted admittedly does not carry a sense of chronology or order, but such is the nature of a stream of consciousness.[55] It is 'experienced subjectively as a continuous flow […] an uncontrolled train of thought or association'.[56] Bleuler's suggestion that this narrative signified a 'flight of ideas' typical of a disordered mind, contradicts the 'stimulus word'

[54] *OED,* 'stimulus' <http://www.oed.com/view/Entry/190384?redirectedFrom=stimulus#eid> [accessed 9 April 2014]. Italics added for emphasis.
[55] Of course, we each harbour connections and associations which are unique to our life experience and context. Therefore, from an external perspective, it can be impossible to appreciate or judge the viability of connections which are entirely subject to the individual.
[56] *OED,* 'stream of consciousness' <http://www.oed.com/view/Entry/191418?redirectedFrom=stream+of+consciousness#eid> [accessed 22 April 2014]

context: the word 'key' was 'carefully selected', intended purely to prompt a surge of ideas.[57] Bleuler seeks 'orderly arrangement' and has invalidated the narrative of the 'patient' when none is evident, and yet the nature of the context makes methodical composition nearly impossible, even irrelevant. 'Orderly arrangement' becomes the unachievable signifier of 'sanity' in a context which demands that the 'patient' articulates their ideas in a chaotic fashion.

Kraepelin's narrative framing also serves to sabotage any potential relationship between the 'mad' self and reader. By introducing the voice of his 'patients' as a 'mere series of letters, syllables or sounds', Kraepelin has reduced such narratives to the material value of the language which shapes it: *just* letters, *just* sounds.[58] The 'madness' narrative is belittled as an 'empty speech act'.[59] Psychoanalyst and literary critic Julia Kristeva described the narrative of an outsider as 'a weight of meaninglessness, about which there is nothing insignificant'.[60] Psychiatry dismisses 'madness' narratives as 'meaningless', in a prelude to dissecting them in great detail, attributing vast significance to language use which is stifled under the weight of such scrutiny: every narrative detail is exposed as proof of 'otherness'. That which is perceived as meaningless speaks of a 'struggle between annihilation and survival to reclaim a sense of self': a poignant human fight for identity after a disorientating experience of illness.[61] This instead becomes *non*-communication, and there is, indeed, 'nothing insignificant' about this process of recontextualisation. The individual, personal narrative – which could potentially offer a counter-narrative – is consumed and controlled by a totalitarian narrative which reconstructs and devalues it.

[57] Bleuler, *Textbook*, p. 73.
[58] Kraepelin, *Dementia Praecox*, p. 42.
[59] Lovell, 'City is My Mother', p. 356.
[60] Kristeva, *Powers*, p. 2.
[61] Lovell, 'City is My Mother', p. 360. Italics added for emphasis.

Delimiting the Limitless: Articulating the Self Through Taxonomy

The 'failure of translation' established in chapter one can, in theory, be resolved – or at least assuaged – when the 'patient' narrates their experience of 'madness' using not their idiolect, but approved psychiatric terminology.[62] An example can be found in *Dementia Praecox and Paraphrenia*, where Kraepelin observed that, for the most part, 'patients' exhibit 'no *real* understanding of the gravity of the disorder'.[63] However, Kraepelin also remarked that 'certain insight into their diseased state' occasionally revealed itself: significantly, this 'insight' is manifest in the 'patient' accepting the 'authority' of the psychiatrist.[64] Kraepelin gave the example of a 'patient' who, replied 'to the question whether he was mentally affected […] "Yes, of course! If one is sensible, one does not do such things!"'.[65] Throughout *Dementia Praecox and Paraphrenia*, Kraepelin explicitly introduced the narrative of the 'patient' as an example of a symptom, often with a blatant reminder to the reader of the 'otherness' exhibited.[66] However, with the *insightful* 'madness' narrative above, Kraepelin offered little commentary and no overt judgement. In narrative terms, this allows the individual experiencing 'madness' to reach a social audience, on the condition that such an account ratifies hegemonic discourse.

Kraepelin recounted the narrative of a 'quite sensible and reasonable' 'patient'.[67] The 'patient' reported how, as their ailment developed, 'I did not trust myself any longer', at which point a psychiatric intervention took place: the 'patient' had submitted the self to psychiatric 'authority'.[68] The psychiatrist interpreted this acceptance of hegemonic discourse

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[62] Freud, *Complete Letters*, p. 208.
[63] Kraepelin, *Dementia Praecox*, p. 151. Emphasis in original. A position of real and comprehensive insight is, presumably, reserved solely for the psychiatrist
[64] Kraepelin, *Dementia Praecox*, p. 150.
[65] Ibid.
[66] The terms favoured by Kraepelin in *Dementia Praecox* to introduce and condemn 'madness' narratives which refuse to conform to or reject psychiatric 'authority' include 'incoherent' and 'incoherence' (which, collectively, feature over fifty times); 'silly' (used over thirty times); to 'meaningless' (employed seven times); to 'bewildering' (which also featured seven times).
[67] Kraepelin, *Dementia Praecox*, p. 104.
[68] Ibid.

as insight, and he commended the 'patient' on how he 'observed himself most accurately' and 'recognised quite clearly the morbidity of the disorders'.[69] A narrative which affirms the expectations established by psychiatric discourse (in this case, the assumption that 'madness' cannot manage or 'trust' itself and therefore requires psychiatric intervention) is familiar and thus socially accepted, particularly when such narratives are delivered merged with hegemonic voices. Is the case study context a space in which the self can be configured, communicated, and, ultimately, 'cured'? Or does the limited nature of this context – particularly the restricted terminology available – damage or misrepresent 'madness', further disenfranchising those attempting to articulate their experiences beyond the language of 'otherness'?

In the absence of any absolute sense of self, the psychiatric language imposed on the 'patient' can become an inherent part of the individual's identity. As Kraepelin stated, the individual experiencing 'madness' is 'not a human being any longer', they are *the* schizophrenic, *the* manic depressive, *the* neurotic. [70] 'Patienthood' is not transient. Although mirroring psychiatric language potentially bridges the abyss between 'madness' narrative and mainstream society, it also limits the self to a permanently disenfranchised position.

A poignant example of this conflict features in Kraepelin's *Dementia Praecox and Paraphrenia*. A 'patient's' voice emerged:

> My thoughts are directed in the right way […] The arrival [to the asylum] has done me good: but I am somewhat weak in my nerves. I shall take pains to direct my thoughts […] I am no longer so melancholy, have lost my knowledge terribly.[71]

There is an evident echo of psychiatric terminology: the 'patient' has reflected the language of Kraepelin's diagnosis, configuring the self through phrases such as 'weak in my nerves' and 'melancholy'. The language and ideology of psychiatry has been accepted and internalised. The 'patient' believed that incarceration had instigated improvement and will

[69] Kraepelin, *Dementia Praecox*, p. 105.
[70] Kraepelin, *Dementia Praecox*, p. 27.
[71] Kraepelin, *Dementia Praecox*, p. 101.

ultimately lead to recovery: Hegel's claim that 'cure' must be sought through an adoption of conventional language seems appropriate here. By embracing the psychiatric model and terminology, the 'patient' has configured the self by using 'otherness'. Twice, the 'patient' described feeling as though their thoughts were being 'directed', and that doing so was a conscious, deliberate and uncomfortable process. The 'patient' has left dimensions of the 'madness' experience unspoken in favour of adopting psychiatric discourse, thus affirming expectations of what 'madness' is at the expense of an authentic articulation. Finally, the 'patient' declared that they have 'lost […] knowledge terribly.' Lacan characterised 'madness' as 'a kind of non-knowledge': it represents an anomaly in the grand narratives of reason and conventional language.[72] However, this loss of knowledge can instead be reclaimed as a struggle to reconfigure the self: the 'patient' has experienced a rupture between prior assumptions of self and the new identity imposed by psychiatric intervention. This loss is 'terrible', devastating: struggling to piece together the self from fragments of psychiatric language, the 'patient' experiences 'ungrounded identity'.[73]

Often, the 'patient' has adopted physical language to articulate an experience of 'madness'. This, again, reflects an attempt to echo medical terminology, but also has further consequences in terms of reclaiming the self through an ordeal of illness. Another case study from *Dementia Praecox and Paraphrenia* demonstrates this:

> Sometimes I am outwardly so animated, so emotional, sometimes again inwardly. My blood is always so unfaithful, my animation is, however, different, sometimes inward life, sometimes outward life: I feel that so. I am just weak in my nerves, weak and weakened in my whole body […] I will yet live.[74]

The 'patient' has mirrored Kraepelin's diagnosis of a weakness of nerves, and thus has internalised a discourse which denotes abnormality in a similar fashion to the previous case

[72] Cutler, 'Philosophical Coquetry', p. 93.
[73] Lovell, 'City is My Mother', p. 356.
[74] Kraepelin, *Dementia Praecox*, p. 107.

study.[75] To be weak could denote passivity, suggesting that the 'patient' has submitted to psychiatric forces. This narrative is articulated in much more physical terms: there is a sense of fatigue which extends to their 'whole body', attributed to 'unfaithful' blood. While this demonstrates an acceptance of the role of medicalised subject, the self is not exclusively articulated using psychiatric terminology. In fact, the narrative can be read as a statement of defiance: the emotional states of the narrator fluctuate – they are transient – and the final assertion that the 'patient' 'will yet live' suggests a tenacious sense of self.

However, describing an experience of 'madness' in terms of 'life' and 'blood' – fundamental components in Western perceptions of humanity – does suggest something which has overridden the narrator's experience of mutable emotional states. These terms imply hereditary, and thus inevitable, 'madness', rooted in the corporeal self. The narrator 'will yet live', but there is a sense of acceptance that 'madness' is a perpetual state of emotional and physical 'otherness' which results in 'either stigma or social death'.[76]

The acceptance of psychiatric discourse permeates both the perceived identity and the perceived narrative worth of lived accounts of 'madness'. In the context of case studies, the impact of hegemonic discourse on the sense of narrative value, particularly in instances where the 'mad' self is constructed as an unreliable narrator, can be overwhelming and uncomfortable. A poignant example can be found in Kraepelin's *Dementia Praecox and Paraphrenia*, as a 'patient' reflected that 'when one reads all this [their 'madness' narrative] it seems to be the greatest nonsense, that was ever written down […] Probably only an expert will be able to give further information about it'.[77] The 'patient' has surrendered any sense of dominion over their personal experience: they do not consider themselves an 'expert' on their selfhood and their experiences. Psychiatry intervened to construct the self through a diagnosis, and this 'expertise' overwhelms any existing presumptions of identity. This

[75] Faris, 'Cultural Isolation', p. 156.
[76] Kleinman, *Illness Narratives*, p. 26.
[77] Kraepelin, *Dementia Praecox*, p. 107.

individual has submitted to psychiatric 'authority' to the extent that it has influenced the way they perceive both their own narrative, and the 'value' of such a document.

However, the 'authority' of psychiatric discourse can sometimes be challenged – albeit subtly – by the voice of a 'patient' who is adamant that they are an expert by experience. There are instances where the 'patient' adopted hegemonic discourse as a form of ventriloquism, but the narrative still functioned as an attempt to protect the self from the psychiatric gaze. Kraepelin's *Clinical Psychiatry* includes the following case study, with the questions of the psychiatrist shown in square brackets:

> [Why are you here?] Because I am the empress […] megalomania, empress
> [Do you feel well?] Oh, thanks very well, since the government has given me permission we will be good friends […] Ah, let me write something
> [Why are you here?] Insane. Megalomania.
> [What is that?] Nothing, nothing, at all.[78]

Defined as 'delusions of power or self-importance […] lust for power [and] a desire to control', the diagnosis of 'megalomania' demonstrates that Kraepelin assigned a label, language and a social role to the 'patient' in question.[79] This narrative exhibits a power play true to form from a 'patient' who allegedly 'desires control' to the extent of it being considered a form of 'madness'.

The psychiatrist offered prompts designed to encourage a surrender to the 'patient' role: by asking 'why are you here?' twice, the alienist clearly tried to elicit a form of acceptance from the 'patient'. However, the 'patient's' initial response was defiant, signifying a position of supremacy – an empress – rather than an acceptance of the role of disenfranchised subject. The 'patient' then reflected the language of the psychiatrist, offering her diagnosis as her reason for incarceration. On the surface, this was a surrender to the psychiatric narrative, an internalisation of 'I am here because I am insane, as exhibited by this

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[78] Emil Kraepelin and A. Ross Defendorf, *Clinical Psychiatry: A Textbook for Students and Physicians* (London: Macmillan, 1902), p. 32.
[79] *OED*, 'megalomania' <http://www.oed.com/view/Entry/115883?redirectedFrom=megalomania#eid> [accessed 14 April 2014].

psychiatric label'. However, when the answer is concluded with a return to a perceived position of power – 'empress' – it renders the relationship between the 'patient' and psychiatric discourse merely superficial, a form of ventriloquism. The notion of identity which endures is that of power, not of submission.

This is further emphasised at the end of the exchange. The psychiatrist repeated the prompt 'why are you here?', creating another opportunity for the 'patient' to submit. By answering 'insane' and 'megalomania' in short, staccato bursts, the 'patient' has again imitated and even debased the language of the psychiatrist. There is no elaboration: the answer is merely an echo of taxonomy. The 'patient' was asked what that *means*: an attempt by Kraepelin to try and gauge insight, as if the psychiatrist is attempting to ascertain to what extent the role has been accepted alongside the taxonomy.

However, this exchange demonstrates that this assent can actually be superficial. Deprived of, or beyond, 'conventional linguistic abstractions', the 'mad' individual develops 'a certain awareness of their arbitrariness and possible absurdity'.[80] Language can, to an extent, be parroted and performed, its superficiality and contingency exposed. While the apparently 'delusional' language of this exchange served to disrupt the narrative process and inevitably resulted in the narrative being 'closed to interpretation' in a wider social context, the 'patient's' sense of self has resisted psychiatric forces.[81] Enduring despite 'the disfigurements of [psychiatric] language', the 'patient' parodied the language but did not accept it. Taxonomy did rupture the sense of self. These classifications have 'no purchase on their object'.[82] In terms of the 'patient's' identity, taxonomy means 'nothing, nothing, at all'.

The 'patient' recognised, and actively sought, the cathartic effect of formulating a narrative, commanding Kraepelin to 'let [her] write something'. Reminiscent of Perkins Gilman's unnamed narrator in *The Yellow Wallpaper,* who declared that she 'must say what I

[80] Sass, 'Ineffable', p. 322.
[81] Lovell, 'City is My Mother', p. 356.
[82] Foucault, *History of Madness*, p. 195.

feel and think in some way – it is such a relief': this desire to write and speak accentuates the vital importance of constructing a narrative.[83] Even Freud acknowledged that 'telling things is a relief […] If the excitation is denied this outlet it is sometimes converted into a […] hysterical phenomena of retention'.[84] However, this contradicts the entrenched pattern of silencing which dominates the case study context. The role of the narrative is recognised as a vital process by both the 'patient' and – to an extent – the psychiatrist, at least in the context of Freud's 'talking cure'. Yet why does the governing psychiatric discourse go to such lengths to censor and silence the voice of the 'patient', and how does this shape the relationship between the 'mad' self and the language of 'madness'?

'The Consecrated Discourse': 'Madness' beyond Hegemony[85]

Hegel and Lacan both argued that 'the madman is incapable of experiencing a meaningful world or of having a coherent sense of existing as a subject of language or experience': the 'madman' is experiencing something 'other' (as in, beyond the realms of conventional language) and so he becomes 'other'.[86] Is language malleable enough to accommodate an 'othered' experience, or does *any* attempt to express 'an interiority that can never be externalized […] to de-limit the limitless' immediately distort, devalue or miscommunicate lived experience of 'madness'?[87]

Kraepelin observed that 'patients show a tendency […] to play with words, to twist them', describing this process as 'senseless'.[88] However, there is also potential to view this as 'taking poetic licence', an attempt to reconfigure and shape the wider narrative of language in

[83] Charlotte Perkins Gilman, *The Yellow Wallpaper* (London: Virago, 2005), p. 21.
[84] Sigmund Freud and Joseph Breuer, *Studies on Hysteria*, ed. by Alex Strachey (Harmondsworth: Penguin, 1974), p. 288.
[85] Kraepelin, *Dementia Praecox*, p. 56.
[86] Sass, 'Ineffable', p. 321.
[87] Shoshana Felman, *Writing and Madness* (California: Stanford University Press, 2003), p. 82.
[88] Kraepelin, *Lectures*, p. 24.

order to find a space for the self in the realm of semantics.[89] In the context of the case study narrative, this alternative use of language is perceived as a symptom – as 'delusional' language – rather than a creative endeavour or a struggle to articulate the self. Kraepelin illustrated his argument with two examples, both of which transcend conventional psychiatric notions of what 'madness' is.

One 'patient' described their experience as 'being punished a little, by my imagination', while another reflected that 'I've got something in my head'.[90] The idea of 'madness' as a form of moral punishment is a common theme throughout case study narratives, and incorporates ideas of sin, absolution and shame which add another, metaphoric, dynamic to the relationship between psychiatrist and 'patient'. Some 'patients' use the language of judgement and punishment as a means of understanding their ordeal, frequently, and significantly, seeking forgiveness from the force of 'authority': the psychiatrist.[91] Aside from the uncomfortable politics of the alienist occupying a pseudo-deity role, the relationship between 'madness' and imagination recontextualises the experience from the language of 'otherness' to one of ingenuity. Someone who is creative to the point of 'madness' (or, indeed, 'mad' to the point of creativity) is certainly socially perceived as less culpable than someone experiencing a form of 'madness' induced by 'imaginary female trouble', 'laziness', 'masturbation' or 'bad whisky'.[92] The link between mental illness and creativity is socially familiar, to the extent of it having become a cliché. Rather than being a 'mere series of letters, syllables or sounds', unconventional language use can instead be seen as an innovative endeavour for semantic self-sufficiency.[93]

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[89] Wolcott, 'Schizophrenese', p. 133.
[90] Kraepelin, *Dementia Praecox*, p. 20.
[91] One of many examples of this can be found in Bleuler's *Textbook*, as a 'patient' requested absolution from Bleuler: 'Dear good Doctor, help me […] Heavenly Father, please don't forsake me […] Have pity on my sinful self, O Doctor, do forgive me once more ' (p. 76).
[92] Causes for admission as recorded from1864 to 1889 for Trans-Allegheny Asylum, see Emma Tracey, 'Ouch Blog', *BBC News* <http://www.bbc.co.uk/news/blogs-ouch-24674564> [accessed 19 April 2014].
[93] Kraepelin, *Clinical Psychiatry*, p. 42.

To return to the second quotation from Kraepelin's *Dementia Praecox and Paraphrenia,* the 'patient' articulated an experience of 'madness' using physical terms ('I've got something in my head'). The individual anchored their ailment in the tangible reality of the body – the 'head' – rather than the abstract realm of the mind: this does not necessarily denote an acceptance of psychiatric 'authority'. Kleinman explained that it is 'a testament to the subtlety of culture that we share such a wide array of understandings of surface meanings of symptom terms'.[94] Because of this desire for 'surface meanings', a complaint such as a headache is articulated as an *ache* of the *head* – something tangible and literal – rather than an abstract ailment of the mind, the unseen and uncontrollable.

The 'patient' who had 'something in [their] head' amalgamated the mind with the brain. 'Madness', no longer an abstract concept, is articulated through physical terms: a *thing* rather than a *thought*. This stands in opposition to taxonomy, which is formulated with prefixes and suffixes which denote deviations of the mind, such as 'phrenic' ('of or relating to the mind')[95] and 'dement' ('out of one's mind').[96] However, 'madness' is also portrayed as something internal: it is unseen, in the head, rather than something phrenological, apparent on the exterior of the body. It is a phenomenon beyond the gaze of the psychiatrist. 'Madness' explained using quantifiable terms (rather than the 'vegetal myth[s]' implied by taxonomy) is easier to comprehend, manage and overcome than something which is linked to abstract notions of cultural normativity.[97] These quotations – although small – demonstrate that transcending the psychiatric construct of 'madness' can alter how the self understands and articulates their experience of 'madness'. Instead of permanently assuming the role of 'othered' 'patient', the individual is able to recontextualise their experience of 'madness'

[94] Kleinman, *Illness Narratives,* p. 15.
[95] *OED,* 'phrenic'.
[96] *OED,* 'dement'.
[97] Foucault, *History of Madness*, p. 194.

from the realm of the abstract and the irrevocable to something tangible and transient, even something which is potentially empowering.

Instead of perceiving 'madness' as an ailment, it can instead be transformed into an affirming, creative and even spiritual experience. John T. Perceval, a 'patient' incarcerated in both Brislington House and Ticehurst Asylum between 1830-32, described his experience of 'madness' in a manner much at odds with the psychiatric definition:

> Nature appeared at times renewed, and in a beautiful medium […] I heard the voices of invisible agents, and notes so divine, so pure, so holy, that they alone perhaps might recompense me for my sufferings. My sense of feeling was not the same.[98]

Potentially, this 'madness' narrative has found a liminal space between the language of 'reason, which masters and represses madness', and 'science, which transforms it into an object'.[99] Here, the 'madness' experience is divorced from the terminology of judgement and stigma enforced by psychiatry. Although 'otherness' is still apparent, it is almost embraced: Perceval articulated an alternative experience of 'reality' with reverential attention to detail; something to be celebrated, rather than a narrative couched in the language of abnormality and shame.

Perceval's narrative challenged the psychiatric hypothesis that 'madness' equates to 'non-knowledge'.[100] 'Madness' is instead portrayed as a form of heightened awareness which suggests it is actually 'sanity' which represents 'non-knowledge'. Perceval reported being able to hear the 'voices of invisible agents […] divine [and] pure', suggesting a 'mystical truth' which lies beyond the boundaries of both psychiatric discourse and 'sanity'.[101] This idea is also evident in literary 'madness' narratives. Poe explored a similar idea in 'The Tell-Tale Heart': 'The disease had sharpened my senses - not destroyed - not dulled them. Above

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[98] John T. Perceval, *Perceval's Narrative: A Patient's Account of his Psychosis, 1830-1832*, ed. by Gregory Bateson (Stanford: Stanford University Press, 1961), p. 69.
[99] Felman, *Writing and Madness*, p. 41.
[100] Cutler, 'Philosophical Coquetry', p. 93.
[101] Sass, 'Ineffable', p. 323.

all was the sense of hearing acute. I heard all things in the heaven and in the earth'.[102] Far removed from the psychiatric conviction that such narratives represent 'nothing more than empty speech acts', 'madness' can instead stand as a testament to the infinite dynamics of human experience, in addition to challenging the perceived omniscience of the psychiatrist.[103] However, psychiatric discourse – although not explicitly present – still hovers over Perceval's narrative to interfere with his interpretation and experience of his 'madness', as Perceval reflected: 'What I call fancies they call "delusions"'.[104]

Post-impressionist Dutch painter Vincent Van Gogh (1853-1890) described his experience of 'madness' in similar terms: 'I am not ill […] I do not think that my madness could take the form of persecution mania, since when in a state of excitement, my feelings lead me rather to the contemplation of eternity, and eternal life'.[105] Despite being incarcerated, Van Gogh did not accept the role of 'patient', maintaining that he was 'not ill' and contending the diagnosis enforced on him. As with Perceval's narrative, a sense of spirituality and affirmation characterised Van Gogh's experience of 'madness'. The striking juxtaposition of limitless experiences ('eternity and eternal life') and an inadequate attempt to delineate this experience using taxonomy ('persecution mania') serves to highlight the gulf between psychiatric construct and personal experience. In a similar fashion, Kraepelin examined a case study in which the 'patient' declares that 'I am perfectly sane and feel myself treated as a lunatic'.[106] Kraepelin, predictably, interpreted this as proof of the 'patient's' 'insanity', observing how 'foreign' the 'extraordinary disorder' of the 'patient' is.[107] However, it again demonstrates potential for the individual experience to undermine

[102] Edgar Allan Poe, 'The Tell-Tale Heart', in *Selected Tales*, ed. by David Van Leer (Oxford: Oxford University Press, 2008), p. 193.
[103] Lovell, 'City is My Mother', p. 356.
[104] Perceval, *Perceval's Narrative*, p. 12.
[105] Vincent Van Gogh, quoted in A. M Hammacher and Renilde Hammacher, *Van Gogh: A Documentary Biography* (New York, Macmillan, 1982), p. 169. Van Gogh's 'madness' and his identity as an artist are explored in detail in chapter four.
[106] Kraepelin, *Dementia Praecox*, p. 13.
[107] Ibid.

hegemonic narratives: the diagnosis (and thus power) of the psychiatrist can be rejected on a personal level.

Several case studies challenge psychiatric assumptions of what 'madness' is, or at least offer a different perspective on how it can be understood. Although they are unconventional in terms of how 'madness' is explained or perceived, they are primarily communicated using orthodox language.[108] As a result, the 'madness' experience is limited to conventional discourse, and this inevitably confines the narrative. For example, psychopathologist and psychologist Louis Sass asked: 'Is the true self or subject something that precedes or underlies language, or does it only come into being through our acceptance and mastery of linguistic forms? What relationship does madness have to that which is (or which is experienced as being) inaccessible or inexpressible through the medium of language?'[109] I have already established a conflict between authenticity and accessibility, but Sass suggests this has a wider impact in terms of the self and social identity. Do we only conceive of selfhood because we have language to do so? If so, when that language is not adequate, is the self obliterated? Or just indeterminately mute? Are these conceptions of the self a privilege only available to those who display a 'mastery' of language? A Hegelian approach would suggest that this is the case: by arguing that 'to be a human self is to be a linguistic self', Hegel demoted the non-linguistic self to a sub-human position.[110] If a fundamental component of identity, such as an overwhelming experience of illness, is 'inaccessible or inexpressible' through conventional language, then what happens to the parts of the self that cannot be articulated, or even comprehended?

The experiences of Anna O. – a 'hysterical' 'patient' under Freud's jurisdiction – exemplify these conflicts. Sadly, we do not have direct access to Anna's voice, and it seems

[108] By which, I mean that such narratives are not reliant on neologisms for articulation.
[109] Sass, 'Ineffable', p. 319.
[110] Berthold, 'Talking Cures', p. 306.

somewhat absurd to rely on Freud – a 'master' of language – to communicate the devastating impact of language failing. Freud's description is our only source of information:

> There appeared a deep-going functional disorganisation of her speech. It first became noticeable that she was at a loss to find words, and this difficulty gradually increased. Later, she lost her command of grammar and syntax […] In the process of time she became almost completely deprived of words. She put them together laboriously out of four or five languages and became almost unintelligible […] For two weeks she became completely dumb and in spite of making great and continuous efforts to speak she was unable to say a syllable.[111]

The fundamental struggle here is one of articulation. Freud's interpretation of the situation is particularly telling: lexical choices such as 'command' suggest that privilege of voice is an assumed human trait, and that any deviation from this implies 'otherness'. Anna was not just unable to find the words to articulate her experience: the grand narrative of language, syntax and grammar had failed her. She was 'deprived' of a functional relationship between language and selfhood, and verbalisation became an arduous challenge: formulating a narrative became 'laborious', requiring a 'great and continuous effort'. As a result of this struggle, she became 'almost unintelligible'.

This conflict is predominantly rooted in politics: Showalter contended that 'the reason why the neurotic fails to produce coherence is that she lacks the power to impose her connections on her reader/listener'.[112] The concept of 'coherence' is also subject to interpretation, and, again, this comes down to narrative framing and reader expectations. This lack of power suggests that the disenfranchised 'patient' has been deprived of the assumed mastery of language necessary to 'impose' connections and ideas – and, indeed, a personal narrative of 'madness' over the implied and expected narrative – onto the reader. However, what remains particularly poignant about Anna's struggle is that she did not accept mutism. Once conventional language failed, she persisted, 'laboriously' amalgamating several languages in an attempt to configure selfhood. Although Freud dismissed these attempts as

[111] Freud, *Hysteria*, p. 77.
[112] Showalter, *Hystories*, p. 88.

'unintelligible', Anna continued to try to construct a narrative to engage with him – to become an active entity in her psychiatric 'treatment' – rather than compliantly submitting to the psychiatrist's gaze.

According to psychiatry, a loss of 'command' of grammar and syntax is a recurring feature in 'madness' narratives which go beyond psychiatric discourse and conventional language patterns. Kraepelin introduced the following case study as a 'mere series of letters, syllables or sounds […] here there is perfectly senseless repetition': 'Ellio, ellio, ellio, altomellio-altomellio – selo, eloo, dello, heloo – f. f. f. dear father, f. f. f. dear father, e. e. f. old and new.'[113] Kraepelin's interpretation suggested that this is a non-narrative, permeated by gutturals and perfect rhymes, it is 'merely' syllables: 'not "meaningful" since they are but casual by-products' of 'madness' and thus 'otherness'.[114] Apparently unworthy of interpretation, the supposedly 'perfectly senseless' narrative is disregarded, considered 'empty'. However, Kraepelin's conclusion places the blame for this failed narrative on the 'patient,' therefore if one is unable to 'command' the grammar and syntax that are necessary for articulating a socially accessible narrative, then one (rather than language, translator, editor or social audience) has failed.

Bleuler's *Textbook of Psychiatry* offers a case study which suggests an alternative perspective. Bleuler asked the 'patient': 'Who is the president of the U.S.?' The 'patient' replied:

> I am the president, I am the ex-president of the United States, I have been a recent president. Just at present I was present, president of many towns […] When you are president you are the head of all, you are the head of every one of those, you have a big head, you are the smartest man in the world […] I am a titled lady by birth of royal blood of rose blood (pointing to another patient) he has black blood, yellow blood, he is no man, a woman, a woe-man.[115]

[113] Kraepelin, *Clinical Psychiatry*, p. 42.
[114] Sass, 'Introspection', p. 6.
[115] Bleuler, *Textbook*, pp. 73-74.

Vocabulary such as ‘incoherent’ and ‘incomprehensible’ permeates the framing of case study narratives to enforce the idea that to be ‘mad’ is to have no control over – rather than control – language. However, the case study above suggests a different relationship with language entirely.

The blurring of tenses initially disorientates the reader, but once the narrative gains momentum, a mastery of language – surely the antithesis of ‘incomprehensibility’ – becomes apparent. Not merely content with answering the question of the psychiatrist, the individual embarked on a meandering narrative journey which serves to undermine both the expectations of what a ‘madness’ narrative is, and also the perceived relationship between the ‘mad’ self and conventional language. The narrative space became a platform for linguistic proficiency as the ‘patient’ seamlessly moved from a half-rhyme (‘president’/‘present’) to a double entendre (‘you have a big head’) to esoteric vocabulary and wordplay (‘woe-man’). How can this possibly fit with Lacan’s assertion that the ‘madman’ does not even recognise the *nom du père,* let alone embrace it?

Although the case studies I have examined all show potential for articulating an experience of ‘madness’ beyond hegemony, they do need to be understood in terms of their potential for social engagement. In order to function, a narrative must articulate the self to a social audience, via a medium. ‘That which is present in the mind has to be re-presented in a commonly acknowledged form before it can acquire validity in the shared “real” world’, and the only ‘commonly acknowledged form’ available to ‘validate’ the ‘madness’ experience is the language of psychiatry.[116] Any narrative which is not re-presented in a socially familiar form will not be validated, and thus the narrative fails. Although I have established that it is possible to discuss and, ultimately, to perceive ‘madness’ in a manner divorced from the psychiatric narrative, this can only happen on a personal level. Psychiatry remains the

[116] Wolcott, ‘Schizophrenese’, pp. 129-30.

'authority' on what 'madness' is, and, as this is the only existing 'commonly acknowledged form', anything which clashes with it is dismissed as 'nonsense'. However, being able to understand 'madness' as something other than a state of 'stigma [and] social death', such as Perceval and Van Gogh's assertions that it was a heightened state of awareness and affirmation, does display potential for the self to be salvaged from the disfigurements of psychiatric intervention.[117] Although identity cannot be narrated s*ocially*, it is a small victory to experience the ordeal of 'madness' – and the psychiatric gaze – without completely submitting to the role of 'patient', of medical subject, and thus of 'other'.

'A Very Eloquent Response': Reading Silence[118]

Philosopher and historian Thomas Carlyle argued that 'under all speech […] there lies a silence that is better. Silence is deep as Eternity; speech is shallow as Time'.[119] In the context of 'madness', to narrate is a form of self-exposure, and thus to be silent is to refuse to engage. As I have shown, 'madness' narratives which are verbalised are dissected by psychiatric forces and socially discarded; the self which is not articulated is protected.

This refusal to engage with language ultimately destabilises the politics of the 'patient'/psychiatrist relationship, which are necessary to reaffirm psychiatric hegemony. In some contexts, silence represents submission.[120] However, silence can also equate to power.[121] The psychiatrist's dominance is based on a mastery of language, but silence removes the psychiatrist/'patient' dynamic from the realm of the written and the verbal.

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[117] Kleinman, *Illness Narratives*, p. 26.
[118] Porter, *Social History*, p. 34.
[119] Thomas Carlyle, *The Works of Thomas Carlyle*, ed. by Henry Duff Traill (Cambridge: Cambridge University Press, 2010), p. 27.
[120] For example, biblical teachings. See I Timothy 2:11, 'Let women learn in silence with all submission'.
[121] These dynamics are complicated by the idea of *tabula rasa* – a 'blank slate' – a concept dating back to the seventeenth century, although later developed and widely attributed to Freud and philosopher John Locke. Described as 'a rhetorical extreme, an image of utter human malleability', there is a branch of psychotherapy whereby the psychiatrist remains silent: a 'blank slate' (see Robert Duschinsky, '*Tabula Rasa* and Human Nature', *Philosophy*, 4 (2012), 509-29 (p. 509)). The silence of the psychiatrist – far from being submissive – denies the 'patient' any form of validation, thus rendering the 'madness' narrative into a state of limbo, as the narrative process remains incomplete.

Although this means the self must remain mute, to be 'mad' and to be silent is to deprive psychiatry of the tools which perpetuate psychiatric hegemony.

In the absence of suitable language, is mutism the only way to protect selfhood from the psychiatric gaze? For Perceval, silence was an alternative to self-exposure: he believed verbalisation would only further alienate his experiences. He explained that neither the medical profession nor a wider social audience 'would understand my motives, or give credit to facts they had not themselves experienced'.[122] Unable to configure his ordeal into 'a commonly acknowledged form' necessary to 'acquire validity in the shared "real" world', for Perceval, silence represented a total refusal to enter into *any* form of social exchange.[123] Significantly, the psychiatric presence interpreted this silence as a form of submission, even a symptom: 'the first symptoms of my derangement were that I gazed silently on the medical men […] My silence, I suppose, gave consent'.[124] Perceval also acknowledged a sense of isolation in the unarticulated experiences of the self, recalling 'sorrow debarred from expressing itself'.[125] Unable – or consciously refusing – to engage with psychiatry does mean that the individual is incapable of actively challenging their position of 'patient'. However, silence also means that the individual is not actively conforming to the role of 'patient'.

Kraepelin described instances of silence as almost lethargic: 'he [the 'patient'] feels no desire to speak at all. He certainly hears and understands what is said to him very well, but he does not take the trouble to attend to it'.[126] In the context of stimulus words and prompts designed to encourage an acceptance of the 'patient' role, to be silent is to 'not take the trouble' to gratify, or even acknowledge, the process of exchange necessary for the 'patient'/psychiatrist dynamic. It is significant that, to Kraepelin, such a symbolic silence denotes only indolence rather than a proactive rejection of psychiatric 'authority'. This serves

[122] Perceval, *Perceval's Narrative*, p. 121.
[123] Wolcott, 'Schizophrenese', pp. 129-30.
[124] Perceval, *Perceval's Narrative*, p. 120.
[125] Perceval, *Perceval's Narrative*, p. 53.
[126] Kraepelin, *Clinical Psychiatry*, p. 394.

to diminish any significance the silence may carry over into a social context: it merely indicates 'no desire to speak', rather than a mute political protest.

In the absence of Anna O.'s narrative, Freud offered one, recounting the case in his own words. We are informed that 'for two weeks she became completely dumb and in spite of making great and continuous efforts to speak she was unable to say a syllable'.[127] This is a different type of silence – at least according to Freud's interpretation: it represented an *inability* to speak, rather than a conscious decision not to. Freud then reflected that 'she could find no tongue in which to speak'.[128] Silence – voluntary or otherwise – signifies a chink in the armour of hegemony. Anna O's mutism unnerved Freud because it recontextualised their relationship: the psychiatrist is the master of language, but if the 'patient'/psychiatrist exchange moves beyond the realm of the verbal, then this 'authority' is threatened.

Dora is perhaps considered Freud's most controversial case study, and her mutism has been read by feminist scholars as a 'silent revolt'.[129] Freud described Dora's silence as the most 'troublesome symptom' of her hysteria, culminating in a 'complete loss of voice'.[130] Her story, transcribed by Freud (although, significantly, 'not narrated absolutely word for word') is a power struggle from the outset.[131] Her father pleaded for Freud to 'bring her round to a better way of thinking'.[132] Dora's 'hysterical' thoughts are deemed subversive: Freud, with his empirical knowledge and overtly sexual interpretations, apparently represents a 'better way' of thinking. Freud attempted to superimpose his narrative onto Dora's experiences: 'he wanted to help [her] by teaching her to talk – to talk about the important things he said she repressed: bedwetting, masturbation, lesbianism'.[133] Dora's silence

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[127] Freud, *Hysteria*, p. 77.
[128] Freud, *Hysteria*, p. 93.
[129] Diana Fuss, *Identification Papers: Readings on Psychoanalysis, Sexuality, and Culture* (London: Routledge, 1995), p. 116.
[130] Sigmund Freud, *A Case of Hysteria*, trans. by Anthea Bell (Oxford: Oxford University Press, 2013), p. 17.
[131] Freud, *Case of Hysteria*, p. 6.
[132] Freud, *Case of Hysteria*, p. 21.
[133] William Clark, *Academic Charisma and the Origins of the Research University* (London: University of Chicago Press, 2006), p. 430.

represents a refusal to couch her experience of 'madness' in the vocabulary of deviation and 'otherness'. Indeed, her mutism epitomises a refusal to attach *any* language (and thus the inevitable stigma and/or social roles latent in such terminology) to her experience.

Describing Freud's psychoanalysis as 'disempowering', academic and writer Ritchie Robertson introduced the case study as a conflict between the governing psychiatrist and the disenfranchised 'patient'. Robertson asserted that 'Freud applauds his own persistence; he speaks of using facts against the patient and reports how he overwhelmed Dora with interpretations, pounding away at her argument, until "Dora disputed the facts no longer"'.[134] Freud interpreted Dora's silence as *his* victory, and the fact that she ended treatment becomes a convenient scapegoat for any criticism Freud may have faced from his contemporaries: 'the treatment did not go on […] but was cut short by the patient's own wish […] if I had continued my work on it I would certainly have reached an ultimate conclusion on all points'.[135] Dora's mutism did make her identity vulnerable, as Freud was able to rewrite her narrative without resistance: her silence could be interpreted however Freud chose, and, in this instance, could be – and was – used to further psychiatric hegemony. Her refusal to engage with the psychiatric process becomes 'transference of her vengeful feelings to me [Freud]', and the reason why Freud's analysis remains 'incomplete'.[136] Dora's silence deprived Freud of his conclusion and thus his complete case study. Despite the fact that her father 'put her [Dora] in my [Freud's] hands', Dora did not submit to this process of exchange. Although her silence allowed her to become Freud's *tabula rasa*, the language used to described Dora's 'revolt' suggests a mute form of power: Freud informed his reader of how she 'rejected medical assistance', 'resisted' the family doctor and that 'any suggestion of consulting another doctor met with opposition from her'.[137] Dora endeavoured to protect

[134] Ritchie Robertson, Introduction, in Freud, *Case of Hysteria*, p. *li*.
[135] Freud, *Case of Hysteria*, p. 7.
[136] Freud, *Case of Hysteria*, p. 105.
[137] Ibid.

her sense of self from the psychiatric gaze: refusing to adopt Freud's language of lesbianism and masturbation, she instead opted – resolutely – for silence.

Silence can result in a personal victory at the expense of the narrative process. There is a significant refusal to enter the 'patient'/psychiatrist dynamic, and thus to submit to psychiatric 'authority'. However, silence and unorthodox language are not a 'commonly acknowledged form' available to 'validate' the narrative in a social context: the only vehicle available to articulate the 'madness' experience in a manner which is socially validated is the language of psychiatry.[138]

'How Were the Mad to Speak and by Whom Could They be Heard?' Concluding Statements[139]

The case study model potentially offers a vehicle through which a 'madness' narrative can be delivered from a microcosmic social exchange (of 'patient'/psychiatrist) to a wider social audience. By containing 'madness' narratives, the psychiatric text delivers them to their readership, a necessary component of the narrative process. Due to occupying a position of absolute power, the alienist can, potentially, use this space to display 'madness' narratives which speak of the vast diversity of human experience: the assumption that 'mad' equates to 'otherness' could, hypothetically, be deconstructed as the 'madness' narrative and psychiatric discourse meet. Alternatively, by exploiting a position of 'authority', the psychiatrist can edit, reconstruct and enforce the language of 'otherness' onto such narratives, thus further affirming the social alienation of the 'mad' individual. Lived experience has the potential to undermine psychiatric hegemony, by establishing the individual as the 'authority' instead. To neutralise this threat, the psychiatrist/editor consumes 'madness' narratives, recontextualising

[138] Wolcott, 'Schizophrenese', pp. 129-30.
[139] Olga Cox, 'Ill Said Ill Heard: Psychoanalytical and Other Discourse on the Language of Madness in the Early Years of this Century', *American Imago*, 4 (1996), 307-24 (p. 309).

them from ‘Human Documents’ to *non*-communication: merely ‘language […] reified as symptom’.[140]

The presence of narrative framing goes beyond the literal thresholds of the text: the ultimate paratexts are the expectations we harbour about what a ‘madness’ narrative will be like and what it means, as informed by psychiatry. Narrative framing – in a more literal sense – also serves to enforce expectations onto the reader: primarily, that the implied, ‘mad’ narrator is unreliable. By introducing ‘madness’ narratives using the language of ‘otherness’, the alienist is perpetuating the psychiatric and societal belief that to be ‘mad’ is to be ‘other’, ‘lacking’, and ‘less than’. All of this serves to undermine the voice of the ‘patient’: the narrative has been dismissed before it has even had chance to be accessed by its readership.

If any attempt to communicate the self beyond taxonomy results in social alienation, configuring the self using psychiatric discourse seems a necessary evil to convey an experience in socially accessible form. But mirroring taxonomy immediately signifies an acceptance of the ‘patient’/psychiatric dynamic, and results in a necessary surrender. These terms represent much more than just a diagnosis: they ‘have a semantic reality and [are] also the label for a certain social role [...] a microsocial crisis situation in which the acts and experience of a certain person are invalidated by others’.[141] ‘Madness’ represents a marginalised, (non)social role which is signified by invalidation, and to accept taxonomy is also to submit to the dominant myth that ‘mad’ is ‘other’.

However, some case studies suggest that this psychiatric language can be mirrored in a form of ventriloquism. In such instances, the vocabulary of the psychiatrist is echoed, without necessarily internalising the ‘otherness’ and ‘patienthood’ latent in this discourse. To an extent, the role of disenfranchised ‘patient’ can be performed to challenge the ‘authority’ of psychiatric discourse, albeit subtly. One of Kraepelin’s *Lectures on Clinical Psychiatry*

[140] Cox, ‘Ill Said’, p. 312.
[141] Cooper, *Language of Madness*, p. 159.

centred on an eighteen-year-old 'patient', who 'almost has to be carried into the room' to be exhibited before Kraepelin's students.[142] The 'patient' displayed an astute awareness of the politics of the 'patient'/psychiatrist (and, indeed, considering the context of the lecture theatre, spectacle/audience) dynamic: 'I tell you who is being measured and is measured and shall be measured. I know all that, and could tell you, but I do not want to […] you understand nothing'.[143] This 'patient's' *understanding* (contrasted with Kraepelin, who 'understand[s] nothing at all') means he was able to be an active entity – rather than passive subject – in the psychiatric 'game'.[144] This allowed the 'patient' to exert power by paradoxically (albeit superficially) accepting the 'patient' role, as explored by Laing: 'They [the psychiatrists] are playing a game. They are playing at not playing a game. If I [the 'patient'] show them they are, I shall break the rules and they will punish me. I must play their game, of not seeing I see the game'.[145]

The 'patient' Kraepelin discussed 'break[s] the rules' by exposing the politics of the 'game', parodying Kraepelin by mimicking his questions, and refusing to 'turn whore' and obediently play along for the purposes of Kraepelin's lecture.[146] Ever resourceful, Kraepelin denounced the 'patient's' rebellion as 'degenerated [and] *unmeaning abuse*' which reveals the 'patient's *inaccessibility*'.[147] Kraepelin was quick to invalidate the 'patient's' potential counter-narrative which threatens to challenge Kraepelin's 'authority': he encouraged his students to dismiss the 'quite incoherent talk' of the 'patient', deeming it 'only a series of disconnected sentences'.[148] It is clear that the psychiatrist's voice has undermined the 'patient's' narrative and prevented it from being interpreted as anything other than symptomatic of 'madness'. But, by knowing, exposing or *playing* at playing along with the

[142] Kraepelin, *Lectures*, p. 77.
[143] Ibid.
[144] Ibid.
[145] Laing, *Knots*, p. 1.
[146] Kraepelin, *Lectures*, p. 77.
[147] Kraepelin, *Lectures*, p. 78. Emphasis in original.
[148] Ibid.

politics of a ‘game’, is there, at least, something of a personal victory to be celebrated when the ‘mad’ self can perform the role of ‘patient’, while reducing the damage caused by such a role?

Transcending taxonomy as a means of communication seems to be the only way to articulate an experience of ‘madness’ beyond the deviation and ‘otherness’ which psychiatric discourse signifies. In terms of the narrative process, it certainly expresses the ‘true self’ of ‘madness’, rather than being limited by the finite discourse of conventional, medical terminology. [149] Poignantly, these narratives allow ‘madness’ to be verbalised in a way which does not necessitate an assumption of the role of ‘other’. Kraepelin observed how, by refusing to accept the discourse of ‘otherness’ to articulate what were, after all, their own symptoms, some ‘patients’ felt ‘specially privileged’ in their ‘madness’, such as a ‘patient’ who declared, ‘I hear from a distance; not everyone can do that’.[150] Rather than condemning difference, this ‘patient’ celebrated it. ‘Madness’ narratives constructed beyond the ‘otherness’ of psychiatric discourse offer innumerable, varied perspectives on how ‘madness’ can be perceived and understood. ‘Madness’ can be a creative or spiritual experience; it can represent a heightened sense of awareness and knowledge; it can be shaped using transient language to suggest a less permanent impact on the self. These narratives are not configured using a ‘commonly acknowledged form’ necessary for social validation as they contradict both the language and the ideology of psychiatric discourse, and therefore they fail as narrative models. A similar process occurs with instances of silence: a mute narrative is not an adequate conduit between self and social audience, as it is represented as *non*-communication, rather than as a symbolic, powerful silence.

Although these narratives are not able to reach a social audience, they do represent a personal victory: ‘madness’ *can* be discussed beyond the realm of taxonomy and ‘otherness’,

[149] Sass, ‘Ineffable’, p. 319.
[150] Kraepelin, *Dementia Praecox*, p. 13.

and one can echo the language of psychiatry without having to accept the implied 'otherness'. Psychiatric framing encourages the reader to dismiss such narratives as 'nonsense' in order to deprive them of any semantic or symbolic significance. But does this not suggest that psychiatric discourse is threatened by 'madness' narratives? To go to such lengths to diminish the reliability – and thus readability – of the narrator certainly implies a knee-jerk defensive manoeuvre. Cooper argued that 'madness' represents a capacity for 'the destructuring of the alienated structures of an existence and the restructuring of a less alienated way of being'.[151] Any narrative which refuses to conform to psychiatric discourse displays the potential for psychiatric hegemony to be deconstructed. By portraying 'madness' as something other than 'other', such as a spiritual experience or part of a creative process, narratives such as those of Van Gogh and Perceval show that it is possible to talk about 'madness' in a way which does not instantaneously signify 'otherness'. This is further reinforced by a rejection of the 'patient' role. If the 'mad' individual can avoid occupying the position of subservient 'patient', then is there not scope for the 'madman' to find or create a new, social identity, divorced from a limited and limiting psychiatric context?

[151] Cooper, *Language of Madness*, p. 40.

CHAPTER THREE

‘An Illusion of Exteriority’: Rereading Literary ‘Madness’[1]

In society, ‘madness’ plays many roles, the majority of them contradictory: it is the unseen spectacle; the absent presence; the voiceless yet ventriloquised. Academic and writer Allan Ingram argued that such ‘dizzying paradoxes’ characterise and obscure the way that ‘madness’ is understood in a social context.[2] ‘Madness’ is removed from the social sphere, and then returned to it in the form of parody or a neatly controlled psychiatric narrative, something which denotes detachment: ‘an illusion of exteriority designed to perpetuate the myth of our own objective distance’.[3] This (mis)representation or reduction of ‘madness’ reflects and reinforces the ideas established by psychiatry. Any potential counter-narrative which challenges psychiatric ‘authority’ is disregarded, subdued and reframed. As I demonstrated in chapter two, in the realm of hegemonic discourse, the omnipresent psychiatrist represents the narrative of reason, of ‘sanity’, of all things tangible and explicable: a ‘madness’ narrative is shown to have no authentic space or voice in this regulated context.[4]

However, narrative boundaries, constructions and expectations in fiction are, by their very nature, less regulated. Kraepelin called attention to the ‘peculiar, distorted turns of speech – senseless playing with syllables and words’ which apparently render ‘madness’ narratives incoherent.[5] But what *is* fiction, or poetry, if not playing with syllables and words,

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[1] Wiesenthal, *Figuring Madness*, p. 17.
[2] Ingram, *Cultural Constructions*, p. 1.
[3] Wiesenthal, *Figuring Madness*, p. 17.
[4] My use of the term ‘omnipresent’ here refers to the ‘continually encountered’ psychiatric presence which overwhelms the ‘madness’ narratives I examined in chapter two. See *OED*, ‘omnipresent’ <http://www.oed.com/view/Entry/131248?redirectedFrom=omnipresent#eid> [accessed 9 January 2016].
[5] Kraepelin, *Lectures*, p. 24.

reconfiguring language to reflect the innumerable variants of emotion and experience? Could it be that literature is a more forgiving medium for narrating 'madness'? Can poetic licence allow for a language *of* 'madness' – the 'sublimating discourse' that Kristeva termed 'aesthetic' and 'mystical' – to enter social consciousness, in contrast to and to challenge the 'scientific or rationalist' psychiatric language which currently dominates?[6] Can literature – a medium which aspires to 'suit the action to the word, the word to the action […] to hold as 'twere, the mirror up to nature' – offer a true reflection of 'madness'?[7]

As established in chapter two, in a psychiatric context, to accept hegemonic discourse is to submit to its power, and to the inevitable ramifications that it has in terms of identity. However, in literature, there is more depth and more room for negotiation. Instead of the oppressive psychiatric narrative, with its limited and limiting taxonomy, literature explores 'the borderless "state" of madness as a realm of wholly indefinite conceptual latitude and longitude'.[8] Literature offers 'an archive of madness […] depict[ing] elements of fantasy, resistance, resilience, tenacity, resourcefulness, and creativity that can be labelled, depending on context and circumstance, either as positive qualities or as deviant entities'.[9] In literature, there is the potential to deconstruct the supposed black-and-white binary of 'madness' and 'sanity', between 'positive qualities' and 'deviant entities'. Rather than *just* being a spectacle, literary 'madness' can be the spectacle in the mirror: 'madness recognised as the mirror of a self', of human experience, and of society as a whole.[10] This is due to a radically different relationship between 'madness' and readership, necessitated by form: fiction must, indeed, 'hold […] the mirror up to nature', it must reflect and engage the reader, rather than cause the reader to dissociate from the 'mad' narrator, as I have shown was the case in psychiatric

[6] Kristeva, *Powers*, p. 7.
[7] William Shakespeare, *Hamlet*, in *Complete Works*, ed. by Jonathan Bate and Eric Rasmussen (London: Macmillan, 2007), III. 2. 12-16.
[8] Wiesenthal, *Figuring Madness*, p. 15.
[9] Baker, *Madness*, p. 2.
[10] Ingram, *Cultural Constructions*, p. 98.

discourses.[11] In fiction, the reader is implicit: literary 'madness' raises 'a dualistic concern with interpretive as well as representational processes'.[12] Although narrative framing still exists, in both a literal and metaphorical sense, it is neither as obtrusive nor as straightforward as it is in a case study context.

A reader expects to be drawn from 'reality' into the reading experience; to be able to immerse him or herself in a fictional world. This requires character development, a plot and, crucially, connection between reader and characters. This is a relationship which psychiatric narratives purposely avoid, and yet this connection is vital to the literary reading process: 'madness' cannot be only a Sensationalist plot device or a Gothic sub-text in order for this emotive bond to develop. Academic and writer Judy Cornes contended that nineteenth-century literature pandered to 'an obsession with individual identity [which] pervaded Western world thinking'.[13] Individual experience is championed over the grand narrative of psychiatry: a dramatic reversal of the case study context in which the individual voice was merely circumstantial to the purpose of the psychiatric text.

This chapter explores an array of 'madness' narratives, examining their presence in a cross-section of texts which inevitably overlap in their interplay between language and 'madness'. The range of literary sources is varied, but by no means exhaustive (as limited by the confines of this thesis). Each text is representative of a genre or idea which was prevalent throughout the nineteenth century, and which is thus able to exemplify the broader discourse of 'madness' in literature. This chapter, in a similar fashion to my analysis of case study narratives, will be structured by how language is used to articulate a 'madness' narrative.

I begin by examining narratives which incorporate, echo, or rely on, psychiatric discourse as a means of communicating 'madness', particularly when this language is

[11] Shakespeare, *Hamlet*, III. 2. 12-16.
[12] Wiesenthal, *Figuring Madness*, p. 2.
[13] Judy Cornes, *Madness and the Loss of Identity in Nineteenth Century Fiction* (London: McFarland, 2008), p. 5.

employed by the ‘mad’ individual. What role do psychiatric narratives play in constructing the identity of ‘mad’ characters? Are these semantic choices deliberately employed by the author as a means of evoking the stigma that inevitably comes with such terms, conjuring up ideas of ‘otherness’ to instigate shock and fear in their readers? Does this language reduce ‘madness’ to a plot device, a 2D role, much as psychiatry reduces the individual to the diagnosis assigned to them? Or is this language used to expose the problematic nature of such reductions? Can such discourses function as psychiatry’s prologue; an alternative discourse which accepts taxonomy while also acknowledging that there is a narrative – and that there are experiences – beyond the confines of a diagnosis?

In this section, I examine the role of psychiatric discourse in Edgar Allan Poe’s ‘The Tell-Tale Heart’ (1843), particularly in light of the assumption that a ‘mad’ narrator is an ‘unreliable’ one, thus requiring psychiatric governance. My textual analysis then covers both the Gothic and Sensation genres, with a specific focus on the narrative of Renfield in Bram Stoker’s *Dracula* (1897), and Lady Audley in Mary Elizabeth Braddon’s *Lady Audley’s Secret* (1862). Both characters clash with – and inevitably submit to – psychiatric forces, and thus both novels contemplate the place and identity of the individual in psychiatric discourse (both as a narrative and as an institution). By comparison, I explore representations of ‘madness’ in Alfred Lord Tennyson’s ‘Maud’ (1855). I examine the portrayal of the ‘mad’ narrator before and after a psychiatric intervention, thus deconstructing Tennyson’s use of – and portrayal of – psychiatric language and power.

Psychiatric discourse permeates these texts, both literally and metaphorically. It goes far beyond an echo of taxonomy, and its theories resonate in more abstract and pervasive ways. The insinuation that ‘mad’ is ‘other’ *is* psychiatric discourse: the idea that ‘madness’ must be removed from the social sphere and incarcerated, managed and made into a spectacle is the assumption that ‘madness’ is not part of mainstream society, and should be treated

accordingly. Therefore, any descriptions of 'mad' as 'other' will be deemed part of hegemonic discourse of what 'madness' *is*. This 'otherness' assumes many forms: it is found in the belief that the 'madness' narrative is incoherent or worthless, 'nothing but idiot gabble!'[14] The use of the individual narrative as a psychiatric tool (to prove a symptom, for example, as exhibited in chapter two) can be mirrored in the employment of 'madness' as nothing more than a plot device. Psychiatric discourse represents much more than a frame of language: it is how we understand 'madness'. It is the foundation on which we construct social meanings of 'madness'. My focus in this chapter lies in how my chosen fictional texts acknowledge, mirror or challenge this discourse: is it that these ideas are so firmly embedded in the social consciousness that it is impossible to describe 'madness' without them? Are these stereotypes employed subconsciously, automatically, indulging the reader's expectations of what 'madness' is? Or are these assumptions parodied, incorporated merely to show their irrelevance in light of the individual experience?

As a point of comparison, I examine narratives which transcend – or totally reject – psychiatric language as a means of communication. Beyond hegemonic discourse, themes emerge: 'madness' is often described as a creative, spiritual experience characterised by acute sensitivity and a new way of seeing the world. 'Madness' can function as a form of self-awareness, as a new identity, or as an affirmation or development of the self (or selves). It can be an experience of knowledge, from which other characters, and indeed, the reader, can learn: even erudite Professor Van Helsing contemplated that he may 'gain more knowledge out of the folly of this madman than I shall from the teaching of the most wise'.[15] Any description of 'madness' which indicates it can be something beyond 'non-knowledge' or *non*-communication, or even just human experience, transcends psychiatric discourse.[16]

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[14] Alfred Lord Tennyson, 'Maud', in *The Works of Alfred Lord Tennyson* (Hertfordshire: Wordsworth Editions, 1994), II. V. IV. l. 1.
[15] Bram Stoker, *Dracula* (London: Oneworld Classics, 2008), p. 239.
[16] Cutler, 'Philosophical Coquetry', p. 93.

I also consider overt rejections of taxonomy, and any implication that 'madness' can be constructed beyond this language. In Poe's short story, 'The System of Doctor Tarr and Professor Fether' (1845), Maillard – the apparent psychiatric 'authority' – insists that 'the word "lunacy" was never employed' in the *maison de santé* he governs.[17] This text will be analysed in light of its potential to subvert dominant narratives by literally confusing the 'patient'/psychiatrist dynamic, and therefore blurring the 'sane'/'insane' dichotomy. Further, I explore Charlotte Perkins Gilman's portrayal of 'madness' in *The Yellow Wallpaper* (1892), focusing on how the text grants insight into the internal monologue of the 'mad' narrator as she attempts to comprehend and communicate the self, and simultaneously to reject psychiatric and patriarchal forces around her.

Selected texts which represent 'othered' states are examined: each of these narratives represents either hallucinatory experiences or multiple selves – subversions of 'normality' that are 'irresistible to the literary mind'.[18] These experiences transcend the assumption that the self is 'unitary, individualised, permanent […] impermeable to spirituality and otherworldliness'.[19] I also briefly explore Poe's short story, 'William Wilson' (1839); and Lewis Carroll's *Alice's Adventures in Wonderland* (1865) and *Through the Looking-Glass* (1867). These texts threaten to destabilise the psychiatric concept of an hallucination through intimate narrative techniques: after all, what is fiction if not what Foucault termed a 'common hallucination', another world, the product of an imagination?[20] The reader is complicit in the apparent delusions of the protagonists: the boundary between 'reality' and something 'other' becomes distorted. These texts which construct 'madness' as something other than 'other' evidently feature a counter-narrative which challenges psychiatric discourse. How are the

[17] Edgar Allan Poe, 'The System of Doctor Tarr and Professor Fether', in *Selected Tales*, ed. by David Van Leer (Oxford: Oxford University Press, 1998), p. 269.
[18] Oliver Sacks, *Hallucinations* (London: Picador, 2012), p. 268.
[19] Lovell, 'City is My Mother', p. 355.
[20] Foucault, *History of Madness*, p. 36.

readers encouraged to respond to these narratives: could authors be presenting these ideas as a means of introducing a new currency to talk about and understand 'madness'?

Finally, I explore narrative gaps or silences. In my previous chapter, I established the power dynamics involved in silence, particularly in relation to the 'patient'/psychiatrist relationship. 'Madness' narratives inevitably instigate vulnerability, as 'open communication is often thought of as obscene self-exposure'.[21] A recurring theme in the literature of 'madness' is the unspeakable which, much like silence in the case study narrative, exposes the inescapable instability of language, regardless of context. This, again, is due to the assumed omnipresence of the psychiatrist: to go beyond the allocated psychiatric discourse to speak of 'madness' is to enter the realm of the ineffable. Although poetic licence allows a creative approach to verbalising 'madness', there is still an expectation that such literature will conform to conventional narrative patterns: it needs to be *readable* in order to be *read*. Is this silence indicative of self-preservation (on the part of the 'mad' character, or even the author)? Or is it an act of resignation, an acceptance that language just *cannot* articulate 'madness'?

'Shutting Madness up in Literature': Echoing and Reinforcing Psychiatric Discourse[22]

Academic Valerie Pedlar contended that 'madness for nineteenth-century writers was [...] an alien state of mind', an 'otherness' to be explored or scrutinised through the medium of the text.[23] This statement, although a problematic generalisation, is illustrative of just how

[21] Breuer, 'Irony', p. 110.
[22] Shoshana Felman, quoted in Wiesenthal, *Figuring Madness*, p. 17.
[23] Valerie Pedlar, *The Most Dreadful Visitation: Male Madness in Victorian Fiction* (Liverpool: Liverpool University Press, 2006), p. 1. This representation of 'madness' as an 'alien' state is a common nineteenth-century trope, with the French term *aliéner* meaning 'to become insane', thus equating 'insanity' with something unfamiliar and dehumanised (see *OED*, 'alien' <http://www.oed.com/view/Entry/4989#eid7109048> [accessed 29 January 2016]). This is made manifest in the term 'alienist', a nineteenth-century term used to describe a psychiatrist: the suffix 'ist' denotes 'a votary of, or expert in' therefore the psychiatrist is the 'authority' on the 'alien' 'mad' (see *OED*, 'ist').

influential and pervasive psychiatric discourses of 'madness' are.[24] Pedlar elaborated that 'imaginative representations of madness are inevitably influenced by cultural conceptions of insanity', and that the psychiatric insistence that 'mad' is 'other' is undeniably *the* prevalent discourse which impacts heavily both on literary representations and on cultural (mis)understanding.[25] The psychiatric narrative permeates social consciousness, from which literary depictions are constructed which inevitably corroborate psychiatric discourse: they are essentially a repackaging of hegemonic narratives, delivered neatly back into the social realm as a reaffirmation of what 'madness' is. [26] This narrative reinforces the assumed power of psychiatry, and so the cycle continues, perpetually marginalising individual experience.

Literary representations of 'madness' simultaneously embody the potential to silence and to speak *for* the individual, although that ventriloquism can in itself be a form of silencing. It can encourage condemnation, or allow 'madness' to be heard. In the realms of the literary text, 'madness' can be the 'other' or it can be reconstructed as a mirror, as our abject self. Literary critic Shoshana Felman observed that 'madness silenced by society has been given voice by literature', championing literature as a space in which the fictionalised 'mad' self can be articulated and thus socially validated.[27] However, Felman countered that 'that literature itself is obsolete', so firmly embedded in the process of stigma and 'othering' – so far removed from the individual voice – that it can never be used as an objective medium for talking about 'madness'.[28] It is evident that literature, as the product of a culture, cannot wholly escape the hugely influential psychiatric discourse, but to what extent are hegemonic narratives actively employed, and their 'authority' reinforced?

[24] I will later discuss how the mirror of the text can actually make 'madness' familiar.
[25] Pedlar, *Dreadful Visitation*, p. 1.
[26] This is a conscious oversimplification which I will later complicate, but I have used it here for the purpose of illustrating how *damaging* a reaffirmation of psychiatric narratives can be.
[27] Felman, *Writing and Madness*, p. 15.
[28] Ibid.

‘Why *Will* You Say That I Am Mad?’ Resisting and Reaffirming Psychiatric Discourse in ‘The Tell-Tale Heart’[29]

Edgar Allan Poe’s literature and mind have both frequently been the topic of psychoanalytical scrutiny: he ‘became, and remains, the most popular subject for psychoanalytic criticism’.[30] Academic and writer David Galloway described Poe as ‘the most perennial victim of the *idée fixe*, and of amateur psychoanalysis of the most blatant variety’.[31]After the death of his wife, Poe himself observed that he ‘became insane, with long intervals of horrible sanity’, experiencing hallucinations that are now believed to have been related to excessive alcohol consumption.[32] Poe, in theory, was well-placed to offer an authentic portrayal of ‘madness’, informed by first-hand experience, rather than shaped by psychiatric discourse alone.

Poe’s short story ‘The Tell-Tale Heart’, published in 1843, is ‘founded solidly on Gothic tradition’, demonstrating Poe’s attempt to manipulate the genre to ‘create fine psychological fiction’.[33] By revisiting the existing topography of the Gothic, Poe sought to develop it, transforming it into a psychological commentary which reflects the wider milieu. Liberated from the ‘mad’ ‘otherness’ latent in the Gothic tradition, Poe could, in theory, transcend it and portray ‘madness’ as something *familiar*, or at least ‘satirize the society which has produced the “mad” individual’.[34] In light of Poe’s intentions to offer a psychological narrative, rather than using ‘madness’ as a superficial plot device, it seems contradictory that ‘The Tell-Tale Heart’ is a text primarily constructed using psychiatric discourse.

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[29] Poe, ‘Tell-Tale Heart’, p. 193. All further references will be given in the main body of the text.
[30] Ronald C. Harvey, *The Critical History of Edgar Allan Poe's The Narrative of Arthur Gordon Pym: A Dialogue with Unreason* (Oxon: Routledge, 1998), p. 63.
[31] David Galloway, Introduction, in Edgar Allan Poe, *The Fall of the House of Usher and Other Writings*, ed. by Peter Ackroyd and David Galloway (London: Penguin, 2003), p. *xxxiii*.
[32] Poe, quoted in Introduction, in Poe, *House of Usher*, p. *xliv*.
[33] Benjamin F. Fisher, ‘Poe and the Gothic Tradition’, in *The Cambridge Companion to Edgar Allan Poe*, ed. by Kevin J. Hughes (Cambridge: Cambridge University Press, 2002), pp. 72-90 (p. 84).
[34] Branimir M. Rieger, *Dionysus in Literature: Essays on Literary Madness* (Bowling Green: Bowling Green State University Popular Press, 1994), p. 8.

The text itself is concise and therefore necessitates economical character development. Use of the first-person narrative ensures that the reader quickly forges a connection – however reluctant – with the unnamed narrator, as he is the only source of information.[35] The narrator immediately constructs and communicates his identity using psychiatric discourse, and this has inevitable ramifications for the relationship between 'mad' self and readership. The opening paragraph reads paradoxically as a defence of selfhood in the light of such discourse and as a verification of the narrator's 'otherness':

> True! – nervous – very, very dreadfully nervous I had been and am; but why *will* you say that I am mad? The disease had sharpened my senses – not destroyed – not dulled them. Above all was the sense of hearing acute. I heard all things in the heaven and in the earth. I heard many things in hell. How, then, am I mad? Hearken! and observe how healthily – how calmly I can tell you the whole story. (p. 193)

Repetition of terms such as 'nervous' and 'mad', and the reference to 'disease', immediately evoke psychiatric discourse.[36] However, the narrator accepts his 'nervousness' and admits to having a 'disease', but resists the label of 'madness': this term is framed by a rhetorical question, as if he is inviting judgement from his readers. The themes of 'nerves' and 'disease', although placed in the psychiatric realm in their extreme states, are still recognisable traits of the human condition: the reader will undoubtedly have a point of reference for one, if not both. However, 'madness' is too abstract, too 'other', and it jeopardises the narrator's perceived reliability, in addition to his 'authority' to speak of his own experiences.[37] The narrator rejects the label, and yet it lingers in the mind of the reader despite his claims that he can recount his version of events 'healthily' and 'calmly': two

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[35] There is not actually any explicit reference to the gender of the narrator in the text, but there are subtle indications (such as the reference to 'madmen' (p. 193)). For the sake of space, I will refer to the narrator in masculine terms, although that is not to ignore the ambiguity.

[36] The narrator's preoccupation with his nerves reflected Poe's own concern that he had become 'nervous in a very unusual degree'. See David Galloway, Introduction, p. *xliv*.

[37] 'Reliability' refers to whether or not we are believed – and thus acknowledged – as a source of information in the context of social exchange and communication. To be considered or portrayed as an 'unreliable' narrator is to fail to meet this basic requirement, and therefore the veracity of the subsequent narrative is disregarded. However, to have 'authority' is to surpass this stance of *just* being heard: if you are the 'authority' on 'madness', for example, not only is your narrative heard, but it is also the standard against which other narratives are validated. To be 'reliable' is to be heard; to have 'authority' is to be powerful.

terms which clash with the psychiatric conviction that 'madness' is a state of 'unreliability' and incoherence.

The narrator's description of his 'disease' as entailing 'hearing acute' and a 'sharpen[ing of] my senses' does defy psychiatric discourse, insofar as such traits are associated with heightened awareness, far removed from the assumption that 'madness' represents 'non-knowledge'.[38] However, it does imply 'otherness' – something beyond conventional understandings of the self and human experience – and, as a consequence, the narrator is in danger of losing touch with his reader, of being disregarded as 'unreliable'.

Throughout the text, the narrator protests his 'sanity' in an incessant manner, therefore – paradoxically – constantly reminding the reader to question it. The 'madman's' inability to recognise his 'madness' echoes the cultural assumption that 'the one and only thing that is typical of all lunatics is their inability to comprehend that they are insane'.[39] A declaration of 'sanity' becomes verification of 'insanity', a testament to the apparent need for psychiatric intervention. The 'mad' self cannot recognise that the self is 'mad', and thus an apparently objective 'authority' must be summoned to categorise and 'cure'.[40] Throughout 'The Tell-Tale Heart', the reader assumes the role of the psychiatrist: the evidence of the narrator's state of mind is displayed before them, awaiting diagnosis. The narrative is constructed as a defence, and by making the reader complicit in the labelling and potentially 'othering' process, he or she becomes aware of the arbitrary and complicated nature of such demarcation.

The defensiveness of the narrator echoes hegemonic discourse: he attempts to construct the 'mad' as something 'other', specifically something 'other' than him. For example, he declares: 'you fancy me mad. Madmen know nothing. But you should have seen

[38] Cutler, 'Philosophical Coquetry', p. 93.
[39] H. G. Woodley, *Certified: An Autobiographical Study* (London: Gollancz, 1947), p. 89.
[40] In chapter five, I discuss how, even in our twenty-first-century context, psychiatric discourses and practice still operate on the assumption that 'madness' cannot recognise, and thus, manage itself.

me' (p. 193). The italicisation of 'me' allows for emphasis, distinguishing the self from the earlier mention of 'madmen'. The narrator goes on to describe the 'caution', 'foresight' and 'dissimulation' (p. 193) he employed, suggesting that he is a creature of reason, of rationality, and of knowledge, and therefore far removed from the contrary states associated with 'madness'. This is further reinforced by the narrator demanding: 'would a madman have been so wise as this?' (p. 193). If he is 'wise', he cannot be 'mad'. If he is capable of articulation, sound argument and reason, he is too familiar to the reader to be entirely 'othered'.

The narrator's attempts to defend his 'sanity' become increasingly problematic as he describes his apparently motiveless, premeditated murder of 'the old man' (p. 193) with whom he lives. The narrator argues: 'if you still think me mad, you will think so no longer when I describe the wise precautions I took for the concealment of the body' (p. 196). His defence of the self – evocative of the struggle for identity in the consuming psychiatric narrative – has been trivialised, designed to provoke uncomfortable humour. The reader is encouraged to think that of course the narrator is 'mad': he thinks 'sanity' can be proven by efficiently disposing of a body. This established union of 'madness' and violence reinforces the mainstream portrayal of 'madness' as a threat which must be contained in order to be controlled. The fact that the narrator is a murderer – however meticulous or methodical – ratifies the label of 'madman' which he so vehemently resists.

It is no surprise that, after the details of the murder have been revealed, the narrator's actions – and therefore his identity – are reduced to stereotypical traits associated with 'madness', such as 'foam[ing]' and 'rav[ing]' (p. 197). His auditory hallucination, centred on his conviction that he can hear 'the beating of his [the old man's] hideous heart' (p. 197) under the floorboards, is the final verification that he is the 'mad', 'unreliable' narrator. On the surface, 'The Tell-Tale Heart' conforms to psychiatric discourse: the narrator is constructed using these terms, and, although he resists them, the sense of 'otherness' and

violence is so prevalent in the text that the reader cannot help but decide he *must* be 'mad'. Poe is reinforcing the stereotype that 'madness' is inextricable from criminality: something to be feared and removed from the social landscape. The reference to the narrator's hallucinations further portrays him as fallible, enforcing the psychiatric hypothesis that the 'mad' are '"unreliable" witnesses, subject to hallucinations, delusions and violent tendencies'.[41] This not only damages the relationship between 'mad' self and reader in the context of the short story, but also beyond that. 'The Tell-Tale Heart' offers a 'madness' narrative (albeit a fictional one) which allows society insight into the mind of the 'other'. The fact that *only* 'otherness' can be found verifies the social and psychiatric marginalisation of 'madness'.

Although the 'otherness' of the narrator threatens to reinforce the psychiatric tradition of silencing and alienation, there are subtleties in the text which imply that things are more complicated. The presence of hallucinations – which establishes the narrator as 'unreliable' – could also indicate that no murder took place at all. If the narrator can imagine a heart beating under the floorboards, and an 'Evil Eye' (p. 193), could he not also have hallucinated the murder scene? Although the prevailing message from the text is still that the 'mad' individual is not a reliable source of information (particularly damaging in light of a struggle to communicate the self as an alternative to the governing discourse), the possibility of *hallucinated* violence is less of a threat than perpetrated violence. Although the 'mad' narrator is still irredeemably 'other', he is less likely to be perceived as an active threat.

Notably, the protagonist also exerts narrative control. Pleading his 'sanity' to the reader, the 'mad' character is in a position of power and knowledge. He not only addresses the reader – a connection impossible in the bounds of the conventional psychiatric text – but he is also able to pre-empt their thoughts and assumptions ('you fancy me mad' (p. 193)) and

[41] Cross, *Mediating Madness*, p. 33.

actively imagine them as part of the proceedings (‘Oh, you would have laughed’ (p. 193)). Although Poe leaves the final judgement to the reader, allowing the verdict of ‘insanity’ to be reached, there is the uncomfortable sense that the reader has been part of it all, both of the events of the text, and of psychiatric ‘othering’. Although ‘madness’ is portrayed as something ‘other’, the events articulated in the text have been experienced by both reader and ‘madman’ – even the hallucinations. Can we really condemn the narrator as a homicidal, hallucinating ‘madman’ when we were complicit all along?

Blabbing Physicians and Idiot Gabble: Deconstructing Hegemony in ‘Maud’

In theory, Alfred Lord Tennyson’s capacity as poet laureate gave him a universally acknowledged status, through which he could offer a powerful counter-narrative to psychiatric discourse. Holding the position from 1850-92, his laureateship coincided with the construction of over 20 large asylums, the passing of the 1853 County Asylums Act and the 1890 Lunacy Act: an array of socio-political changes which contributed to the wider (mis)understanding of ‘madness’.[42] Tennyson’s laureateship afforded him a mainstream platform, from which he could offer narratives which addressed and continued debates about how ‘madness’ should be represented and dealt with. However, this position also tied him to convention, forcing him to ensure that his poetry was accessible, readable and relatable.

‘Maud’ is the product of this conflict. Published in 1855, it was part of Tennyson’s first collection as poet laureate, and it embodies opposing desires to speak about ‘madness’ and to be heard. Therefore, ‘Maud’ had to present ‘madness’ as something relatable while simultaneously trying to conform to the hegemonic agenda that characterised psychiatric discourse. This ensured that ‘madness’ was presented in its socially accessible semantic form, guaranteeing readability and appeasing the poet’s audience.

[42] Information taken from Andrew Roberts, ‘Mental Health History Timeline’ <http://studymore.org.uk/> [accessed 9 September, 2014].

Offering an intimate first-person narrative which exposes the internal monologue of an unnamed protagonist, 'Maud' is an amalgamation of various poetic conventions. It incorporates 'the monodrama, the mad song, and the dramatic monologue [and] is constructed from vividly contrasted sections, narrative and lyric'.[43] It is both a pastiche of literary traditions and something entirely original: a body of text which is familiar, yet which, as a whole, surpasses the sum of its parts. This is a fitting analogy for its use of psychiatric discourse. It is the foundation on which the poem is constructed and yet the end result is somehow beyond its realm.

The primary theme is one of unrequited love which appears to destabilise the identity of the narrator, as he struggles to 'keep a temperate brain'.[44] There is an inescapable sense of alienation and isolation. The narrative explores the protagonist's failed romance, his liminal social role as a fugitive when the narrator is forced to flee following a violent altercation with Maud's brother, and the death of the protagonist's father. These events culminate in total marginalisation when he is incarcerated in an asylum. The protagonist resolves to 'bury myself in myself' (I. XIX. l. 4) long before the 'grave' (II. XI. l. 2) of the asylum. The final act of incarceration not only forces a commentary on the psychiatric process, but also creates a direct conflict between psychiatric narrative and the individual voice. It allows a direct point of comparison for the configuration of the protagonist's identity prior to, and during, his contact with psychiatry.

The psychiatric presence in the text is not made explicit until the end of the second section. In theory, this means that, for the majority of the poem, the identity of the narrator is constructed by, and for, the self, without intervention. However, due to its pervasive nature, psychiatric discourse has inevitably influenced the lexical choices made by Tennyson, and thus his narrator, as a means of articulating the 'mad' self. The melodramatic language used

[43] Pedlar, *Dreadful Visitation*, p. 69.
[44] Tennyson, 'Maud', I. VII. l. 4. All further references will be given in the body of the text.

throughout the first section of the narrative allows 'Maud' to function as a prelude to the Sensation genre, with the overwhelming sense of tension and mystery drawing the reader in: 'the roots of my hair were stirr'd/ […] my pulses closed their gates with a shock on my heart as I heard/ The shrill-edged shriek' (I. IV. ll. 1-4).[45] This dramatic opening evokes heightened emotions and a sense of spectacle, and this correlation between 'madness' and the extreme (anger, violence, the 'vitriol madness' (I. X. l. 1)) reaffirms it as the binary opposite of reason.[46] With the grand narratives of the nineteenth century shifting towards rationalism, industrialisation and secularism – championing scientific discourse (the objective) over the spiritual and emotive (the subjective) – to represent reason is to be part of mainstream society. To represent 'unreason', then, is to be excluded. 'Madness' is perceived as a contrary state.[47] The narrator of 'Maud' is immediately constructed in terms of his 'otherness', primarily his emotive subjectivity in the face of a progressively objective society. By depicting 'madness' as a deviation from cultural normativity, psychiatric discourse can be incorporated – and further reinforced – without it even being directly manifested.[48]

Repeated words like 'rave' (I. XV. l. 4), 'sick' (I. XVI. l. 1) and 'nerves' (I. XVI. l. 3) evoke psychiatric discourse. The term 'rave' has Anglo-Norman and Old French origins, denoting an 'other' state of mind: 'to be mad, to behave as if delirious […] to wander in one's mind', later encompassing the elemental[49] and the bestial.[50] However, 'rave' also implies a

[45] Tennyson's marriage of terror and 'roots of […] hair [which] stirr'd' reflect the Latin etymology of 'horror': originating from the Latin term 'horrēre', meaning 'to stand on end (as hair), to bristle. See *OED*, 'horre' <http://www.oed.com/view/Entry/88553#eid1282175> [accessed 9 January 2016].
[46] Tennyson's focus on the corporeal experience echoes contemporary phrenological discourse, which sought to 'discern the outward marks of a mind' on the physical self. See John Conolly, 'The Physiognomy of Insanity', in *Embodied Selves*, ed. by Jenny Bourne Taylor and Sally Shuttleworth (Oxford: Oxford University Press, 2003), pp. 18-21 (p. 20).
[47] As Lewis Carroll explained through the voice of the Cheshire Cat: 'You see a dog growls when it's angry, and wags its tail when it's pleased. Now *I* growl when I'm pleased, and wag my tail when I'm angry. Therefore I'm mad'. Lewis Carroll, *Alice's Adventures in Wonderland*, ed. by Roger Lancelyn Green (Oxford: Oxford University Press, 2008) , p. 58.
[48] At this point in the text, there is no explicit psychiatric presence, but hegemonic discourse is still relied on to describe 'madness'.
[49] 'Of the sea, the wind, a storm […] to rage; to rush or roar furiously'. *OED*, 'rave' <http://www.oed.com/view/Entry/158622?rskey=u38qTF&result=4#eid> [accessed 9 September 2014].
[50] An example of usage from 1848 describes how 'that sow's always raving and revelling so'. Ibid.

problematic relationship with language and communication. To ‘rave’ is to ‘to speak or declaim wildly, irrationally, or incoherently’.[51] It is reminiscent of Porter’s declaration that in ‘mainline views in psychiatric medicine […] it became standard to refer to what mad people said […] through terms such as “chattering”, “jabbering” and “ranting”’.[52] Implications of incoherence and unknowability are prevalent throughout psychiatric discourse, enforcing the idea that to be ‘mad’ is to have no control over language. According to Sass, the ‘mad’ individual ‘is psychiatry’s quintessential Other – the patient whose very essence is “incomprehensibility” itself’.[53]

Tennyson’s repetition of ‘rave’ evokes a form of ‘madness’ so divorced from reason that the individual’s speech and manner become ‘wild’, ‘irrational’, and bestial. It also depicts a human experience which is so ineffable that it cannot be contained in conventional language: Tennyson leaves the reader to decide where the fault lies. Should an experience beyond orthodox language be disregarded as ‘incomprehensible’ and thus not allowed to enter popular currency? Or should language be required to change in order to accommodate the vast array of human experience which is currently silenced by its rigid and limiting structure?

The term ‘nerves’ suggests the nineteenth-century discourse of hysteria, particularly neurologist Jean-Martin Charcot’s hypothesis that ‘madness’ signified a ‘weakness of the nervous system’.[54] Repetition of both ‘nerves’ and ‘sick’ alludes to a deviation from health, but also enforces the idea that ‘madness’ is an inherent lack or difference which overwhelms the body and mind. This ‘otherness’ is fundamental to psychiatric discourse: psychiatric language apparently identifies ‘marked deviation from conventional or normal ways of acting, or thinking, or feeling [...] to make it appear that there must be something lacking in

[51] Ibid.
[52] Porter, *Social History*, p. 32.
[53] Sass, ‘Introspection’, p. 4.
[54] Stone, *Healing the Mind*, p. 101.

the constitutional makeup of the individual'.[55] Charcot's construction of hysteria works on the assumption of weakness in the 'mad' individual, continuing the theme of 'mad' as 'other'. Tennyson employs this hypothesis in his characterisation by mirroring language which equates 'madness' with an absence or an inherent lack – a deviation from the 'norm'. However, by evoking contemporary discourse of nerves and 'otherness', is Tennyson reaffirming or challenging psychiatric hegemony?

The unconventional representation of 'madness' in 'Maud' implies that Tennyson was providing an alternative discourse through which 'madness' can be articulated, but it sits uncomfortably alongside the running theme of 'otherness' in the poem. The isolation of the protagonist allows for a feeling of transcendence, as he describes his 'philosopher's life in the quiet woodland ways' (I. VIII. l. 1), removed from the 'clamour of liars belied in the hubbub of lies' (I. VIII. l. 3). Reminiscent of Emily Dickinson's declaration that 'much Madness is divinest Sense -/To a discerning Eye', there is a suggestion that this self-imposed alienation from a society 'where each man walks with his head in a cloud of poisonous flies' (I. VIII. l. 6) is actually a logical choice motivated by self-preservation.[56] It could be argued that the 'madness' of Tennyson's protagonist, epitomised by alienation and 'otherness', is the only 'sane' response he has available; the only active way to demarcate the self from a corrupt milieu.

Tennyson's construct of the philosophical 'mad' self is fundamental to the relationship between protagonist and reader. In 'Maud', this representation offers an alternative to Voltaire's assumption that alienation occurs merely because the 'mad' individual has *no place*: 'incapable of ideas suitable for society, he is excluded [from it]'.[57] Psychiatric discourse actively and literally removes the 'mad' from the social landscape

[55] Faris, 'Cultural Isolation', p. 156.
[56] Emily Dickinson, '435', in *Emily Dickinson Everyman's Poetry*, ed. by Helen McNeil (London: Everyman, 1997), ll. 1-2.
[57] M. De Voltaire, *The Philosophical Dictionary* (George H. Evans: New York, 1835), p. 151.

under the vague premises of safety, management and 'cure'. However, the desired place for the 'mad' self is never really acknowledged.[58] The idea of 'madness' being shunned by society is a customary theme in any narrative which speaks *about* it, but Tennyson's intimation that the 'mad' individual could actively refuse a social role is certainly radical. If the 'mad' ('other') rejects society ('us'), the presumed binary of 'us'/'other' is entirely subverted, and society becomes the 'other's' 'other'. As philosopher Friedrich Nietzsche contended, 'when you gaze long into an abyss the abyss also gazes into you'.[59] Society and psychiatry may feel that it has successfully neutralised the threat of Tennyson's 'mad' protagonist by incarcerating and containing him. However, the 'babble' (II. V. IV. l. 6) of the 'mad' is indistinguishable from the 'blabbing' of the 'vile physician' (II. V. III. l. 7): the roles of 'us'/'other', rational/incoherent, 'patient'/psychiatrist and, as Nietzsche would argue, gazer/abyss are exposed to the reader as fluid.

Towards the end of its second section, 'Maud' focuses on the incarceration of the protagonist, and therefore his identity is reconstructed by a more explicit psychiatric presence. Throughout these stanzas, his incarceration is described as a 'shallow grave' (II. V. I. l. 6): a liminal state which encompasses both life and death, and the absent and the present. It also evokes the inevitable 'social death' the individual experiences once hegemonic discourse allocates to them the role and language of 'patient'.[60] In this instance, Tennyson conforms to psychiatric discourse insofar as the metaphor of living death denotes a state of *difference* – something that exists in between life and death.

However, the depiction of incarceration as a purgatorial state of living death is also emotionally loaded, and is therefore Tennyson's conscious attempt to forge sympathy from

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[58] Porter described the rise in asylum culture and incarceration as a process whereby the 'otherness' of 'madness' could be contained and handled in a marginalised, pseudo-quarantined space: 'the instituting of the asylum set up a *cordon sanitaire* delineating the "normal" from the "mad", which underlined the Otherhood of the insane and carved out a managerial milieu in which that alienness could be handled'. See Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2003), p. 122.
[59] Friedrich Nietzsche, *Beyond Good and Evil*, trans. by R. J. Hollingdale (London: Penguin, 2003), p. 102.
[60] Kleinman, *Illness Narratives*, p. 26.

his readers. Evoking Perceval's description of the 'death-in-life of a lunatic asylum', death obviously implies trauma and grief, but the idea of being buried alive taps into a latent anxiety.[61] The fear of premature burial was further embedded into social consciousness by the cholera outbreaks of the eighteenth and nineteenth centuries, and the invention of the 'safety coffin' illustrates just how entrenched this anxiety was. The mechanics of this device are best described by Poe in the short story 'The Premature Burial': 'there was', he wrote, 'suspended from the roof of the tomb, a large bell, the rope of which, it was designed, should extend through a hole in the coffin, and so be fastened to one of the hands'.[62] The process of incarceration is presented to Tennyson's readers as a horrifying premature burial, made even more menacing by the silencing force of psychiatry: Tennyson illustrates incarceration as the equivalent of being buried alive, heard but left. This image also alludes to the fallibility of psychiatric judgement. To be buried alive is either to be the victim of someone's error – wrongly assumed to be dead and thus buried – or to be purposefully entombed. Whether malevolent or mistaken, the agency which confined the individual, in the grave or in the metaphorical burial of the asylum, is depicted as problematic and fallible.

The use of the first-person narrative ensures this metaphor goes beyond the realm of the unsettling, towards the truly disturbing. Emotive language and onomatopoeia hijack the reading experience, forcing the reader to empathise with the experience of the narrator:

> The wheels go over my head,
> And my bones are shaken with pain,
> For into a shallow grave they are thrust,
> Only a yard beneath the street,
> And the hoofs of the horses beat, beat
> […]
> I thought the dead had peace, but it is not so;
> To have no peace in the grave, is that not sad? (II. V. I ll. 4-16)

[61] Perceval, *Perceval's Narrative*, p. 3.
[62] Edgar Allan Poe, 'The Premature Burial' (Chester: NetLibrary, [n.d.]) [accessed 17 September 2014], p. 8.

This conflict between language of 'otherness' (of dissociation) and language of human experience (and thus of familiarity) underscores the entire text, but is foregrounded during the consecutive stanzas. The 'us'/'other' distinction is further complicated, with the narrator describing the sense of unity among 'patients', as indicated by the first person plural pronoun 'us' (II. V. III. l. 1). This constructs the asylum as a social microcosm, where the 'vile physician' (II. V. III. l. 7) is the 'other' because of his 'sanity'.

By contrast, psychiatric language is used to depict the other characters in the asylum, indicating Tennyson's reliance on this discourse in order to construct the identity of a 'mad' character. Dramatic, emotive terms such as 'sobbing' (II. V. III. l. 1) and 'distress' (II. V. III. l. 2) evoke an absence of rationalism and reason which portray 'madness' as 'other'. The psychiatric assumption that 'madness' is a 'kind of non-knowledge' is evident in semantic choices such as 'fool' (V. I. III. l. 6) and 'idiot' (II. V. IV. l. 1).[63] Reference to hallucinations and delusions reflects the psychiatric contention that the 'mad' are '"unreliable" witnesses' which serves to undermine the perceived *worth* of the 'madness' narrative.[64] The mention of a 'patient' who considers himself 'lord of all things' (II. V. III. l. 3) inevitably instigates doubt (were it not already present) in the mind of the reader concerning the 'reliability' of our narrator. The narrative has been reconfigured in the space and language of psychiatry so the reader is reoriented and the power of the dominant narrative is reinstated. The foregrounded identity of the protagonist is no longer that of grieving son, of spurned lover, of philosopher or even that of narrator: he is a 'patient'. He is 'mad', no longer deemed a reliable or valid source of information. The 'madness' narrative becomes 'nothing but idiot gabble' (II. V. IV. l. 1), 'merely […] babble' (II. V. IV. l. 6) and it is no coincidence that the entire narrative concludes shortly afterwards.

[63] Cutler, 'Philosophical Coquetry', p. 93.
[64] Cross, *Mediating Madness,* p. 33.

Although this conscious employment of psychiatric language does impact on the relationship between 'madness' narrative and reader by evoking 'otherness', Tennyson does not construct 'madness' solely in these terms. By providing an insight into the identity of the 'mad' self prior to contact with psychiatry, the reader is shown that there is an alternative (albeit one which is later consumed by 'otherness').[65] Throughout the penultimate stanza of the poem, the protagonist muses: 'still I am but half-dead;/Then I cannot be wholly dumb' (II. V. XI. ll. 4-5). This is a fitting summary of the conflicting 'madness' discourses in the text. The narrator is 'half-dead'; his previous identity has been usurped by taxonomy and 'otherness' and he is caught in a purgatorial alive/dead, absent/present state. The *worth* of his narrative has been disregarded by psychiatry, by the assumption of his 'unreliability'. However, to be 'half-dead' is also to be 'half-alive', and so he still has a voice, albeit one stifled by hegemony. By granting the 'mad' character narrative space, Tennyson has ensured that his protagonist 'cannot be wholly dumb', despite the individual text being both produced, and consumed, by psychiatric discourse.

The Pet Lunatic versus the Philosopher: Reading 'Madness' through *Dracula's* Narrative Layers

Written in 1897, *Dracula* examines the intersection between the supernatural and the scientific. By focusing on the unnerving 'total lack of human control over a powerful and overwhelming universe', Bram Stoker explores the terrain of the geographically, spiritually or mentally 'other'.[66] The assumption of Stoker as a Gothic writer – a genre comprised of 'tales of mystery and horror […] intended to chill the spine and curdle the blood' – seems incompatible with *Dracula*'s narrative focus on the scientific, the medical and the

[65] Shortly, when I discuss Poe's 'Tarr and Fether', I explore the idea that 'madness' only becomes 'other' in the presence of psychiatry, which enforces this marginalisation. In 'Maud', the narrator's 'madness' is only explicitly 'othered' after he has been incarcerated.
[66] Carol A. Senf, *Science and Social Science in Bram Stoker's Fiction* (London: Greenwood Press, 2002), p. 19.

technological.[67] Between these apparently paradoxical discourses of the rational and the spiritual, Stoker's representations of 'madness' could either be pathologised or demonised: either way, in the realm of a novel which handles both Gothic and scientific materials, 'madness' seems destined to be 'other'.

Dracula's fragmented narrative form immediately signifies a different reading approach: the reader is expected to be an active entity, piecing together the story themselves from diary entries, letters, and newspaper articles. Dr Seward's narrative not only allows for a nod to technological advancements ('*Kept in phonograph*' – a narrative style later echoed by Freud): it also provides intimate insight into Seward's interior states.[68] Seward's narrative is an oxymoron: it is both an objective, psychiatric text and an emotive, subjective diary. Seward's account is far removed from apparently impartial psychiatric narratives. The form is also used by Stoker to invite doubt in his readers: we are encouraged to challenge the supposed reliability of our various narrators, as we never receive the whole picture. This narrative medium represents an opportunity to question the 'reliability' of *all* narratives, both in the microcosm of the text, and in grander societal discourses, including psychiatry. However, Stoker's employment of psychiatric discourse indicates that hegemonic narratives are being endorsed, rather than disputed.

Stoker continues to ventriloquize 'madness' through psychiatric discourse, as the reader only accesses Renfield's (the 'mad' individual, and the object of Seward's almost monomaniacal study) narrative through Seward's diary. Renfield's 'madness' represents more than one function for Seward. Not only is he 'a study of much interest' (p. 60), but he is also a distraction for Seward, a 'cure' (p. 60) for the turmoil presented by issues in his private life.[69] Renfield is introduced as 'so unlike the normal lunatic' (p. 60), thus immediately reducing him to psychiatric discourse, both in the form of taxonomy, and the

[67] J. A. Cuddon, *Dictionary of Literary Terms and Literary Theory* (London: Penguin, 1998), p. 356.
[68] Stoker, *Dracula*, p. 60. All further references will be given in the main body of the text.
[69] At this point in the narrative, Seward has just had a proposal of marriage refused by Lucy Westenra.

'patient'/psychiatrist power dynamics evident throughout my analysis of the case study context. Renfield's narrative is consumed in Seward's.

Seward desires to make himself the 'master of the facts of his [Renfield's] hallucination' (p. 60). On the one hand, this demonstrates the psychiatric aspiration not only to understand (or, indeed, (mis)understand) 'madness' but to govern it, to establish political control. It is an abstract form of colonisation: the psychiatrist apparently represents reason, knowledge and coherence, and attempts to enforce these values onto the unknowable 'mad' topography – or, at the very least, to initiate the 'mad' self into a *langue* which articulates 'otherness'. However, Seward's aspiration to be the 'master' of Renfield's 'madness' suggests that he is *not yet* the 'master'. This depicts psychiatric 'authority' as a process – something that has to be achieved – rather than an automatic privilege.[70] Despite being contained and reduced in psychiatric discourse and its institution, Renfield is the 'master' of his own 'madness', blurring any established or expected power dynamics, and denying psychiatry power. He is the autonomous 'madman', governing and protecting the self in the face of psychiatric forces which seek to usurp his identity. In the same paragraph, Renfield's 'madness' is referred to as 'his madness' (p. 60): an experience demarcated as his, not surrendered to hegemony, or reclaimed by the psychiatric presence.

However, Seward continues to discuss Renfield using psychiatric terminology, and in the absence of Renfield's counter-narrative, this becomes the sole point of reference the reader has for characterising him. By describing Renfield in terms of 'otherness', Seward reinforces the power of the dominant narrative, and tries to obstruct the relationship between

[70] Kraepelin described the politics of the psychiatric environment as requiring 'patient' passivity. This enforces a clear hierarchy, enhanced by the culture of institutionalisation, designed to establish psychiatric 'authority' and 'patient' disenfranchisement automatically. See, for example, his claim that 'the patients have lost every independent inclination' (p. 37), interpreting this, of course, as a symptom of 'madness' rather than the result of totalitarian asylum culture. Kraepelin elaborated that 'as the inner activity of volition fails, the resistance which outside influences meet within us is […] easily lost. The patients therefore are usually docile, let themselves be driven as a herd, so that they form the necessary nucleus of those crowds which conform willingly to the monotonous daily rounds'. See Kraepelin, *Dementia Praecox*, p. 37. As discussed in chapter five, this presents 'madness' controlled by psychiatric forces as neutralised; a stark contrast to 'free' and 'autonomous' 'madness'.

Renfield's voice (albeit ventriloquised) and reader, lest Renfield should be heard. Seward observes how '[Renfield's] face fell, and I could see a warning of danger in it, for there was a sudden, fierce, sidelong look which meant killing. The man is an undeveloped homicidal maniac' (p. 68). This sinister, bestial portrayal – alongside the explicit inclusion of psychiatric terminology – constructs Renfield as the 'mad', violent 'other' who is far removed from the supposed reason represented by psychiatry. This depiction relies on 'otherness' to portray Renfield as an antagonist both in Seward's text, and in the wider novel. Stoker has employed the psychiatric hypotheses that 'madness' is something threatening and alien to 'chill the spine and curdle the blood' of his readers – thus the text relies on 'madness' as a plot device.[71]

However, Stoker's lexis complicates this. Seward's declaration that Renfield is an 'undeveloped homicidal maniac' (p. 68) is multifaceted. Seward echoes eighteenth-century discourses which employed almost interchangeably terms such as 'idiots', 'imbeciles' or 'feeble minded' in place of a rigid structure of taxonomy.[72] This language denotes an individual who is 'not fully developed', thus indicating that Renfield is undeveloped, 'other', less than, encompassed in the twin nineteenth-century discourses of degeneracy and phrenology.[73] However, an alternative reading would insinuate that it is Renfield's capacity as a 'homicidal maniac' which is undeveloped: Seward is observing its potential but not its presence. What Seward is actually saying is that Renfield is not yet a 'homicidal maniac', and, therefore, not actually a 'homicidal maniac' at all. This theme of 'otherness', although very much present and pervasive, backfires. Could society, in its entirety, not be reduced to such labels, the *not quite* schizophrenic, the *possible* neurotic? It is an argument reminiscent

[71] Cuddon, *Dictionary*, p. 356.
[72] Thomas Bewley, 'Madness to Mental Illness' <http://www.rcpsych.ac.uk/files/samplechapter/MadnesstoMIllnessSChap.pdf> [accessed 14 May 2012], p. 4. A legal distinction between 'lunatics', 'idiots' and 'imbeciles' was not made until the 1886 Idiots Act (later repealed by the Mental Deficiency Act in 1913).
[73] *OED*, 'imbecile' <http://www.oed.com/view/Entry/91681?rskey=U9gp9Q&result=1&isAdvanced=false#eid> [accessed 14 May 2012].

of Dr Mosgrove's diagnosis in *Lady Audley's Secret* that 'there is latent insanity!'[74] Use of psychiatric language serves only to expose the fluidity of such terminology by revealing the potential for us all to be scrutinised and categorised.

Seward endeavours to create a new taxonomy in which Renfield can be contained, and the reader is granted insight into this process: 'my homicidal maniac is of a peculiar kind. I shall have to invent a new classification for him, and call him a zoophagous (life-eating) maniac' (p. 69). Use of the possessive determiner – '*my* homicidal maniac' – implies that Renfield's 'madness' has been conquered and is therefore now mastered and managed by Seward. Psychiatry has subjugated Renfield's 'madness', and usurped his identity: his self is now owned by psychiatric forces. Once language exists to demarcate and diagnose Renfield, he becomes Seward's 'own pet lunatic' (p. 219): he belongs to psychiatric 'authority'. Pedlar argued that Renfield's 'diagnosis' 'is borrowed from natural science, and the transference underlines the degree to which Renfield is seen as an animal, a specimen for the scientist to observe and catalogue'.[75] As with all psychiatric taxonomy, this is language designed to denote 'otherness' and difference. At this point in the plot, Seward's terminology reinforces the idea that Renfield is just a spectacle, a psychiatric subject. The violent episode which follows Renfield's escape verifies this:

> My patient is too dangerous a person to be roaming about. Those ideas of his might work out dangerously with strangers […] When we closed in on him, he fought like a tiger. He is immensely strong, and he was more like a wild beast than a man. I never saw a lunatic in such a paroxysm of rage before, and I hope I shall not again. It is a mercy that we have found out his strength and his danger in good time. With strength and determination like his, he might have done wild work before he was caged. (p. 97-98)

This establishes an 'illusion of exteriority', allowing Seward – and the reader – to construct Renfield's identity in a way which demarcates him from mainstream society.[76] Seward is

[74] Mary Elizabeth Braddon, *Lady Audley's Secret*, ed. by David Skilton (Oxford: Oxford University Press, 1998), p. 379.
[75] Pedlar, *Dreadful* Visitation, p. 138.
[76] Wiesenthal, *Figuring Madness*, p. 17.

made uncomfortable by the idea of Renfield 'roaming about' and reintegrating with society because it would distort the distinction between 'us' and 'other'. Renfield's physical strength, echoing Poe's description of 'an energy superhuman', is bestial, predatory, it must be 'caged'.[77] This familiar assimilation of 'madness' and violence is prevalent in psychiatric discourse, and it reaffirms the idea that there is no place for 'madness' with the social landscape.

It is ironic that the governing narrative must theoretically empower 'madness' (by constructing it as a violent, physical force) in order ultimately to disenfranchise and silence it (to ensure it remains 'other'). However, Stoker grants Renfield space to manoeuvre in this prescriptive, designated role. Renfield's alleged violence (we must, of course, remember that we have only received this account from Seward) which estranges him from society and from his readers, is internalised and, to an extent, does empower him. Towards the end of the novel, during an altercation with the Count, the reader is presented with an account (albeit second-hand) of Renfield's thought process: 'I had heard that madmen have unnatural strength, and as I knew I was a madman – at times, anyhow – I resolved to use my power' (p. 263). The discourse intended to subdue Renfield is actually one which gives him strength, both literally and metaphorically, allowing for an alternative discourse which equates 'madness' with autonomy and power.

Although Stoker primarily relies on psychiatric language, it is not meekly accepted: lexical details serve to undermine and challenge Seward's psychiatric 'authority'. There are two other representations of 'madness' in the text which need to be analysed in order to comprehend Stoker's overall commentary and, ultimately, the conclusion Stoker encourages his readers to reach.

[77] Poe, 'Tarr and Fether', p. 280.

Renfield's role in the text needs to be deconstructed. Despite the psychiatric presence attempting to dictate otherwise, Renfield is not a character in isolation. He does have a relationship with the wider context of the novel; he is not merely Seward's distraction or study: he is able to transcend the identity of psychiatric subject. Renfield's apparent 'hallucinations' are actually sources of insight to the reader and to the other characters, as 'Renfield's every utterance and movement is a clue to happenings in the larger world of Dracula's invasion'.[78] Renfield is aware of the threat Dracula poses long before the majority of the other characters are and, significantly, before Seward: in this sense, 'madness' is no longer 'non-knowledge', it is a state of knowledge to which not even psychiatry or mainstream society have access.[79] When searching for the Count, Seward reflects: 'goodness knows that we had enough clues from the conduct of patient Renfield' (p. 211). However, the assumption that 'madness' speaks no wisdom results in Renfield being ignored, and this delays the protagonists in their attempts to track down the Count and destroy him.

The most significant passage (insofar as Stoker's representation of 'madness' is concerned) is instigated by this conflict between knowledge and 'non-knowledge'. Renfield understands the imminent threat posed by the Count, and pleads for Seward to move him from the asylum so the Count cannot find him:

> Let me entreat you, Dr Seward, oh, let me implore you, to let me out of this house at once. Send me away how you will and where you will; send keepers with me with whips and chains; let them take me in a strait waistcoat, manacled and leg-ironed, even to a jail – but let me go out of this. You don't know what you do by keeping me here. I am speaking from the depths of my heart – of my very soul. You don't know whom you wrong, or how, and I may not tell. Woe is me! I may not tell! […] Can't you hear me, man? Can't you understand? Will you never learn? Don't you know that I am sane and earnest now; that I am no lunatic in a mad fit, but a sane man fighting for his soul? Oh, hear me! Hear me! Let me go! (p. 231)

[78] Pedlar, *Dreadful* Visitation, p. 143.
[79] Cutler, 'Philosophical Coquetry', p. 93.

Renfield possesses knowledge which he 'may not tell', thus subverting the established power dynamics of 'patient'/psychiatrist.[80] This emotive and urgent plea for protection allows for the reader to empathise with Renfield, although obviously he must declare himself a 'sane man' in order to have his voice acknowledged. His appeal to be heard ('Oh, hear me! Hear me!') extends beyond the context of the novel and allows Stoker to encourage his readers to hear, particularly as Renfield does represent a form of knowledge of which the other characters are ignorant. He addresses Seward as 'man' and later refers to himself as a 'sane man', consequently describing 'us' and 'other' in identical terms. This forces the reader to revaluate their relationship with Renfield: if both 'patient' and psychiatrist are *just* 'men', why should one voice be championed over the other?

The sympathy of the reader is manipulated further when Seward refuses Renfield's request, attempting to demote him from his newly-articulated identity as Seward's equal and return him to his passive role as 'zoophagous patient' (p. 109). Seward counters: '"Come," I said sternly, "no more of this; we have had quite enough already. Get to your bed and try to behave more discreetly"'(p. 232). Later, Renfield is found horribly injured after he is attacked by the Count, just as he had predicted. This knowledge/'non-knowledge' conflict is used by Stoker to reveal 'the stranglehold that the label of madness exerts'.[81] By granting Renfield knowledge which surpasses both that of the other characters and of the reader, Stoker is subverting psychiatric assumptions that 'attending or listening to the voice of the mad is pointless since, by the virtue of their unreason, their views are worthless'.[82] That Renfield is both dismissed and ignored by Seward forces the reader to reflect on the nature of hegemonic narratives which encourage such silencing. Further, Van Helsing – another psychiatric presence in the text – reflects that '[Renfield's] words may be worth many lives' (p. 260).

[80] Particularly topical in light of the growing popularity at the fin de siècle of Freud's 'talking cure' which relied on the verbal information of – and emotional vulnerability of – the 'patient'.
[81] Pedlar, *Dreadful* Visitation, p. 143.
[82] Cross, *Mediating Madness*, p. 25.

However, that Renfield's knowledge is only recognised after he is violently attacked, after there is physical proof of his claims, and after he describes himself as a 'sane man' (p. 231), allows Stoker to suggest that psychiatric (and social) attitudes towards 'madness' are not only tremendously misinformed but also, ultimately, inhumane.

Finally, there is a running theme which confuses – and destabilises – the distinction between 'sanity' and 'insanity'. This technique is threefold. First, Stoker constructs Renfield as a character who may not be contained exclusively in psychiatric discourse. The reader expects a certain performance of 'madness' and, although Seward's narrative attempts to diagnose and detail anomalies, Renfield resists being entirely 'othered' and therefore is not totally estranged from the reader. Evidence of this can be found in Stoker's depiction of Renfield as 'a lunatic who will talk philosophy, and reason so sound' (p. 239). Although Renfield is still primarily described in terms of his perceived 'otherness' – his 'lunacy' – he has the capacity for knowledge and cogent articulation. Since 'madness' is supposed to represent antithesis of reason, it is something of a contradiction for Van Helsing (emblematic of psychiatric discourse) to describe a 'patient' both in terms of his 'lunacy' and his capacity for 'sound' judgement, since it implies that psychiatric discourse is misinformed, and needlessly limiting. Seward marvels at Renfield's 'unusual understanding of himself, which was unlike anything I had ever met with in a lunatic' (p. 228). These depictions are still punctuated by psychiatric vocabulary, but they indicate that such terminology is not the full extent of Renfield's identity. His self-awareness prevails despite the presence of psychiatry. Seward's inability to limit Renfield's identity to the role of 'patient' – and Renfield's refusal to submit – belittle the perceived 'authority' of psychiatry, and so leaves the reader questioning why that assumption of 'authority' existed in the first place.

Second, the 'sanity' of the other characters is challenged. By deconstructing Renfield's 'madness' and questioning the presumed 'sanity' of the other protagonists, Stoker

is presenting ‘madness’ as a spectrum, rather than a Kraepelinian dichotomy. Van Helsing informs Seward that ‘all men are mad in some way or the other’ (p. 113) referring to members of mainstream society as ‘God’s madmen’ (p. 113). This normalisation of ‘madness’ defuses the sense of ‘otherness’ prevalent in psychiatric discourse. Seward later questions Van Helsing’s ‘sanity’, directly asking ‘Dr Van Helsing, are you mad?’ (p. 182), and wondering ‘if his mind can have become in any way unhinged’ (p. 191). Seward, despite being the force which demarcates ‘madness’ from ‘sanity’, grows uncertain of such a binary distinction: ‘I sometimes think that we must be all mad and that we shall wake to sanity in strait waistcoats’ (p. 257). By granting Renfield elements of reason, knowledge and autonomy (and thus ‘sanity’), and forcing Seward and Van Helsing to contemplate the possibility of their own ‘madness’, Stoker exposes the fragility and fluidity of the ‘us’/‘other’ distinction. If the psychiatrist can see himself in the ‘patient’, then the ‘mad’ self is not the psychiatrist’s ‘other’ but his echo, his mirror image.

Finally, Stoker merges the characterisations of Renfield, Seward and Van Helsing to challenge the supposed ‘sane’/‘insane’ binary further. Seward and Renfield are twinned from the opening of the novel, with both men relying on diaries as a means of self-expression. The psychiatric assumption that the ‘mad’ voice is ‘worthless’ is subverted alongside the established power dynamics. Renfield belittles Van Helsing’s ‘authority’, declaring ‘you are the old fool Van Helsing. I wish you would take yourself and your idiotic brain theories somewhere else’ (p. 240).[83] Terms such as ‘fool’ and ‘idiotic’ evoke eighteenth-century discourses of ‘madness’, and so Van Helsing (despite his ‘brain theories’, and his perceived knowledge and power) is reconstructed by Renfield in Renfield’s terms. Taxonomy has been reversed: the psychiatrist has become the ‘patient’. Psychiatry is portrayed not as Renfield’s

[83] Van Helsing’s ‘idiotic brain theories’ echo Voltaire’s claim about doctors: ‘Why a brain has incoherent ideas, is above their comprehension; and they little comprehend why, in another brain, the ideas are regular and connected. They fancy themselves wise, but they are no less mad than he’. Voltaire, *Philosophical Dictionary*, p. 152.

'other' but his other self, his doppelgänger.[84] Renfield challenges Seward, diminishing Seward's perceived reason and power: 'What ridiculous nonsense you are talking!' (p. 254). The 'patient'/psychiatrist dynamics have been subverted. The lunatic has taken over the asylum – or at least its discourse.

'Diagnostics of Madness': Speaking and 'Othering' 'Madness' in *Lady Audley's Secret*[85]

In fiction, the role of 'madness' is also subject to expectations of genre. The tremendously popular Sensation genre, which gathered momentum in the 1860s, aimed to 'keep readers at a fever-pitch of suspense', and frequently incorporated 'madness' as a theme.[86] According to *Punch* magazine, it was concerned with 'Harrowing the Mind, Making the Flesh Creep, Causing the Hair to Stand on End, Giving Shocks to the Nervous System, Destroying Conventional Moralities, and generally Unfitting the Public for the Prosaic Avocations of Life'.[87] It could be argued that 'madness' was thus demoted to a plot device, functioning only to 'creep' the flesh of its Victorian audience. Although the Sensation genre offered 'madness' a 'textual display', it was also voyeuristic, 'exploit[ing] the taste for representations of the horrors of the madhouse'.[88]

However, 'madness', ever irreducible, could not be constricted to such a superficial role. 'Madness', once 'confined to the Gothic subplot – to the narrative and domestic space that Charlotte Brontë call[ed] "the third story"', had taken up a significant space in the centre of the plot and was therefore able to occupy the foreground of the narrative.[89] The oversimplification of 'madness' as a function (much like the belief that a 'madness' narrative has no value other than as a psychiatric tool) still meant that it was permitted narrative space,

[84] Later in this chapter, I discuss the motif of the doppelgänger further in light of Poe's short story 'William Wilson'.
[85] Braddon, *Lady Audley's Secret*, p. 287. All further references will be given in the main body of the text.
[86] Deborah Wynne, *The Sensation Novel and the Victorian Family Magazine* (Hampshire: Palgrave, 2001), p. 2.
[87] Anon, 'Sensation Times', *Punch*, 9 May 1863, pp. 178-96 (p.193).
[88] Wynne, *Sensation Novel*, p. 48.
[89] Elaine Showalter, *The Female Malady* (London: Virago, 1987), p. 52.

and granted a voice through literature. Although not necessarily offering a sympathetic portrayal, Sensation literature opened up a dialogue between 'madness' and readership. This relationship had previously been sabotaged in psychiatric discourses to enforce 'otherness', an 'illusion of exteriority', or a disconnect between reader and 'madness' narrative.[90]

To what extent is Lady Audley's supposed 'madness' (or, indeed, her 'sanity') used by Braddon as a plot device to provoke outrage, shock or – radically – sympathy in her nineteenth-century readership? Lady Audley's relationship with hegemony is complex: it is the foundation on which she communicates her personal and family identity; it is internalised as means of justifying her supposed crimes; she is liberated from it by being declared 'sane'; and yet she is detained in it anyway when incarcerated. Lady Audley's unstable relationship with psychiatric discourse (and its institution) is explored by Braddon as a means of portraying 'madness' as a spectrum on which we are all contained, rather than a binary opposition which marginalises 'madness' as a form of deviation and venerates 'sanity' as the 'norm'.

Immediately, the narrative voice complicates the assumption that Lady Audley's 'madness' is visibly apparent, commenting that 'all mental distress is, with some show of reason associated in our minds with loose, disordered garments, and dishevelled hair, and an appearance in every way the reverse of my lady's' (p. 338). Although this is a commentary very much rooted in the nineteenth-century hypothesis – borne out of theories of phrenology and degeneration – that 'madness' is associated with discernible 'otherness', it has wider ramifications, both in the text and in mainstream society. Braddon is acknowledging the 'wide spectrum of visual stereotypes' which supposedly characterise 'madness', and is demythologising them, exposing the potential for psychiatric discourse to be misinformed,

[90] Wiesenthal, *Figuring Madness*, p. 17.

and for it to misinform society in turn.[91] By challenging part of the ruling narrative by revealing it to be flawed, Braddon is opening up the potential for *all* of the assumptions it makes about 'madness' to be questioned.

Psychiatric discourse, embodied by Dr Mosgrove, is a commanding force in the text. It is enforced by the majority of the characters (symbolically, those who have power, primarily the patriarchal figures in the novel). It is used to subdue Lady Audley, to reconstruct her identity as 'asylum patient' rather than 'patriarchal threat' (indicated by her bigamy and alleged violent behaviour). Robert Audley uses her supposed 'madness' as a means of dissociation, declaring: 'henceforth you must seem to me no longer a woman […] I look upon you henceforth as the demoniac incarnation of some evil principle' (p. 345). There was – and still is, to an extent – an entrenched cultural legacy which amalgamated 'madness' with possession and supernatural forces. Although somewhat displaced by the 'rationality' and 'objective' discourse of nineteenth-century psychiatry, it was still a manoeuvre designed to demarcate the 'other', and thus inevitably formed part of that discourse. Eighteenth-century theologian Hugh Farmer described how demons were perceived to 'deprive men of their reason', and 'madness' lies in this absence of reason.[92] Although pronouncing such demons to be allegorical rather than literal, the cultural marriage of the two endured, finding its way into Robert Audley's understanding of 'madness' in a novel written over eighty-five years later. Lady Audley can no longer be perceived as a woman because she is 'mad' and therefore must be *less-than*, something 'other'. She is literally demonised by Robert so he can construct an 'illusion of exteriority' to distance himself from her.[93]

Lady Audley does not reject psychiatric discourse, and, in a melodramatic fashion true to Sensational conventions, reveals her 'mad' identity during a heated altercation with Robert. Referring to herself as 'a MADWOMAN!' (p. 345), she offers her supposed

[91] Sander L. Gilman, *Seeing the Insane* (New York: Bison Books, 1982), p. 116.
[92] Hugh Farmer, *An Essay on the Demoniacs of the New Testament* (London: G. Robinson, 1775), pp. 2-3.
[93] Wiesenthal, *Figuring Madness*, p. 17.

'madness' as means of justification as Robert accuses her of murdering her previous husband: 'I killed him because I AM MAD' (p. 346). This apparent internalisation of the language *about* 'madness' reveals numerous conflicts, not least the now-familiar trope of the powerful woman being understood as 'mad' as a means of controlling the threat she poses to established societal conventions and assigned gender roles.[94] Braddon is demonstrating Lady Audley's inability to think of herself as anything beyond the realm of 'other', which is particularly insightful given her relationship with her incarcerated mother and her assumption that she will inherit her 'madness', which I will discuss later. Foregrounded in this theatrical dispute between Robert and Lady Audley, 'madness' functions as the 'grand reveal' (arguably the 'secret' to which the title of the novel refers); the climax of the scene; the twist to elicit shocked gasps from the reader. Lady Audley uses it to absolve herself of any criminal responsibility, declaring a defence of 'insanity', reflecting an ongoing social debate borne out of the 1843 Daniel M'Naghten case which instigated a standard test by which the criminal liability of an individual could be assessed.[95] Braddon's use of psychiatric discourse also encourages the reader to question its true application to Lady Audley's identity. If taxonomy is exposed as having a negative, limiting effect on the self, particularly when the supposed distinction between 'sane' and 'insane' is obscured, could hegemonic narratives be revealed as an oppressive, damaging forces, and therefore something to be challenged, rather than venerated?

Despite the dichotomy of 'madness' and 'sanity' which are inevitably conjured up by the use of psychiatric discourse, Lady Audley's articulation of her experiences denotes

[94] Academic trends have done a thorough job of championing Braddon's feminist agenda and liberating Lady Audley from the oppressive patriarchal forces around her, and so this argument does not need to be covered here in any detail. See, for example, *Beyond Sensation: Mary Elizabeth Braddon in Context*, ed. by Marlene Tromp, Pamela K. Gilbert, Aeron Haynie (New York: University of New York Press, 2000) and Lyn Pykett, *The 'Improper' Feminine: The Women's Sensation Novel and the New Woman Writing* (Oxon: Routledge, 1992).

[95] For more information, see J. Thomas Dalby, 'The Case of Daniel McNaughton', *American Journal of Forensic Psychiatry*, 27 (2006), 17-32.

changeability: this represents ‘madness’ as a continuum rather than a black-or-white distinction. Initially, she describes how she perceives her ‘intellect [as] a little way upon the wrong side of that narrow boundary-line between sanity and insanity’ (p. 346), a liminal position for which the psychiatric discourse has no language. Throughout her narrative, her mental state is portrayed as fluid, but not in an erratic manner: any transgressions of that ‘narrow boundary-line between sanity and insanity’ are depicted as a response to her wider social context. When describing her first unhappy marriage – during the course of which she is abandoned and left to raise a child alone – she explains how this desertion acted as a catalyst: ‘I think my mind first lost its balance, and for the first time I crossed that invisible line which separates reason from madness’ (p. 353). Although the psychiatric distinction between reason and ‘madness’ is employed – and thus the primary narrative is upheld – the possibility that the individual can move fluidly from ‘madness’ to ‘sanity’, that the self can return to reason after a transgression, represents ‘madness’ as a transient state, rather than a permanent condition. If an individual is capable of being both ‘mad’ and ‘sane’, then they can never truly be ‘other’. To be ‘mad’ and ‘sane’ means that one is not beyond relatability: there are parts of the self with which mainstream society can empathise. Psychiatric language, which affixes an enduring label on the individual, has no relevance if an experience of ‘madness’ is ephemeral: through this, Braddon reveals the dissonance between psychiatric hypotheses of ‘madness’ and lived experience.

Lady Audley describes how her ‘mind regained its just balance. I had watched myself very closely’ (p. 354), demonstrating both the potential for ‘madness’ to be a transitory state, and also the ability for the individual to manage and understand ‘madness’ without psychiatric intervention. Much like Renfield’s ‘mastery’ of his ‘madness’, Lady Audley has autonomy insofar as she is the active force (the observer), rather than the passive spectacle (the ‘mad’ ‘patient’). Psychiatry conquers in the end, incarcerating her, but not before

Braddon is able to insinuate to the reader that there is potential for 'madness' not only to be configured – but also controlled – beyond the psychiatric realm. The illegitimate nature of Lady Audley's incarceration further challenges the social assumption that an asylum is the just place for the 'mad' individual.

Lady Audley is haunted by her belief that she will inherit her mother's 'madness', and this hypothesis is firmly embedded in nineteenth-century psychiatric discourse.[96] The idea that 'madness' could be transmitted from parent to child 'passed from the level of hunches and prejudice […] to that of scientific endeavour', as psychiatrists sought to locate hereditary influences in the aetiology of 'madness'.[97] Psychiatric discourses could use this theory to pre-empt 'madness', to identify and control it in the individual before it had even been proved.[98] However, Braddon's exploration of innate 'madness', transmitted from mother to child, provokes a sense of empathy from the reader: Lady Audley is deemed helpless as she is unable to escape her legacy. Her troublesome diagnosis of 'latent insanity' (p. 379) (which I shall examine in more detail shortly) ridicules the psychiatric hypothesis of hereditary 'madness': it is too imprecise, too abstract.

Lady Audley is convinced that she will inevitably experience 'madness': the psychiatric assumption of innate 'madness' has clouded her self-perception. She describes how she envisioned her mother, whom she imagines is a prophecy of her future:

> I brooded horribly upon the thought of my mother's madness. It haunted me day and night. I was always picturing to myself this madwoman pacing up and down some prison cell, in a hideous garment that bound her tortured limbs. I had exaggerated ideas of the horror of her situation. I had no knowledge of the different degrees of madness; and the image that haunted me was that of a distraught and violent creature,

[96] Indeed, the possibility of a genetic aetiology for 'madness' still features prominently in hegemonic psychiatric narratives. See, for example, Michael Stone's argument that 'relatives of schizophrenics were [found to be] more likely to develop schizotypal personality […and] a family history of depression doubles or triples the risk for bout(s) of depression'. See Stone, *Healing the Mind*, p. 367-68. The fact that this conversation is still ongoing is particularly significant in light of my later argument that psychiatric discourse has not 'progressed' since the nineteenth century.

[97] Stone, *Healing the Mind*, p. 113.

[98] An idea similar to the objective of phrenologist Cesare Lombroso to diagnose and demarcate those 'predisposed' to crime before they actually display criminal tendencies. See Cesare Lombroso, *Criminal Man*, trans. and ed. by Mary Gibson and Nicole Hahn Rafter (Durham: Duke University Press, 2006).

> who would fall upon me and kill me if I came in her grasp […] and heard her ravings in my ear. (pp. 348-49)

The familiar tropes which portray 'madness' as something 'other'– the violence, the dishevelled appearance, the incoherent ravings – sit uncomfortably alongside Lady Audley's understanding that such preconceptions were merely 'exaggerated' ideas. The acknowledgement that there are 'different degrees' of 'madness' further reinforces the earlier suggestion that such mental states can be viewed aside from the 'sane'/'insane' binary instigated by psychiatry. Braddon is playing with the expectations of her readers, and allowing Lady Audley – the supposedly 'mad' individual – to voice psychiatric assumptions of what 'madness' is. By acknowledging the expectation on the part of her readers that 'madness' encompasses a 'wide spectrum of […] stereotypes', Braddon is then able to deconstruct these assumptions, not least because the reader's (mis)understanding of 'madness' has been pre-empted and ventriloquised through the 'mad' character who should be disenfranchised by such stereotypes.[99]

When Lady Audley finally comes face to face with her mother, she learns that the reality of 'madness' clashes with psychiatric discourse:

> I saw no raving, strait-waistcoated maniac, guarded by zealous gaolers; but a golden-haired, blue-eyed, girlish creative, who seemed as frivolous as a butterfly, and who skipped towards us with her yellow curls decorated with natural flowers [...] her madness was an hereditary disease transmitted to her from her mother, who had died mad. She, my mother, had been, or had appeared, sane up to the hour of my birth; but from that hour her intellect had decayed. (p. 350)

Her mother is vulnerable, child-like, a far cry from the anticipated figure of danger and violence. Dressed in flowers, she is an image of pre-Raphaelite femininity: she 'skipped' rather than 'pacing' like the trapped animal which Lady Audley expected. The explanation that her mother's 'insanity' – just like her own – remained latent up until a moment of pressure (in this instance, giving birth) again implies that 'madness' does not have to be a

[99] Gilman, *Seeing the Insane*, p. 116.

designated identity, but is, instead, a fluctuating and reactive state. By deconstructing Lady Audley's preconception of 'madness' – which mirrors societal and psychiatric assumptions of what 'madness' is – Braddon is forcing the reader to reflect.

Lady Audley's identity is constructed both by psychiatric narratives (particularly her own description of herself as 'mad', and her conviction that she will inherit her mother's 'madness') and beyond it (by suggesting that 'madness' is transient and can be managed by the self). The presence of Dr Mosgrove complicates her perception of self further. Robert Audley calls on psychiatric 'authority' to diagnose and detain Lady Audley, and to remove the threat she allegedly poses both to his family sphere and the wider social body. The character of Mosgrove is contradictory, allowing psychiatry to be represented as fallible. On hearing her story (albeit second-hand, through Robert), he declares 'there is no evidence of madness in anything that she has done' (p. 377), explaining how her actions were dictated by her situation. Once Mosgrove actually encounters Lady Audley, he concludes:

> There is latent insanity! Insanity which might never appear; or which might appear only once or twice in a lifetime. It would be *dementia* in its worst phase perhaps: acute mania; but its duration would be very brief, and it would only arise under extreme mental pressure. The lady is not mad; but she has the hereditary taint in her blood. (p. 379)

The diagnosis of 'latent insanity' – specifically when it arises 'under extreme mental pressure' – is too broad to have any real relevance. It is an umbrella term which threatens to encompass any and everyone, as a temporary extreme of emotion in the face of tremendous pressure is part of the human condition. Her 'latent insanity' – strong emotional responses indicative of an instinct for self-preservation – actually makes Lady Audley familiar, rather than 'other'. The reader recognises him or herself in this 'latent insanity' which means that either society, in its entirety, is 'mad', or that psychiatric understandings of 'madness' create

an 'illusion of exteriority' – of dissociation – when actually there is nothing but an arbitrary label to draw the line between what is 'sane' and 'insane'.[100]

Despite Mosgrove declaring her 'sane', this potential for 'madness' is apparently enough to warrant her incarceration, and she is detained indefinitely in the *maison de santé* in Villebrumeuse. Mosgrove assures Robert Audley: 'if you were to dig a grave for her in the nearest churchyard and bury her alive in it, you could not more safely shut her from the world and all worldly associations' (p. 381). Echoing 'Maud', the reoccurring image of premature burial further encourages the empathy of the reader: the chapter of Lady Audley's detainment is entitled 'Buried Alive', and she later exclaims to Robert that he has 'used […] power basely and cruelly, and […] bought me to a living grave' (p. 391). The implication that psychiatry is a force that can be used 'basely and cruelly' rather than for the perceived benefit of society is a disconcerting one. The reader is again reminded of Lady Audley's 'sanity', as Mosgrove maintains that 'she was not to be called "mad"' (p. 389): a bizarre insistence considering she has just been incarcerated. By undermining the apparent objectivity of the diagnostic process through this act of unjust confinement, Braddon is again highlighting a disconnect between psychiatric 'authority' and the individual. The reader is forced to reflect on this process, particularly as George Talboys – allegedly murdered by Lady Audley – reappears unscathed at the end of the novel after a brief sojourn in New York, and enjoys a peaceful life with his friends and son while the wife he abandoned to poverty dies alone in an asylum.

'I've Got Out At Last': Articulating 'Madness' Beyond Psychiatric Discourse in *The Yellow Wallpaper*[101]

[100] Wiesenthal, *Figuring Madness*, p. 17.
[101] Perkins Gilman, *Yellow Wallpaper*, p. 36. All further references will be given in the main body of the text.

Although psychiatric narratives are perceived to be the 'authority' in terms of articulating and explaining 'madness', and despite them traditionally being the only way 'madness' can be discussed in a socially accessible context, they are, as I demonstrate, not the *only* available means of expression. Communicating 'madness' through unconventional narratives – such as portraying 'madness' as a state of knowledge, of heightened awareness, of creativity or spirituality – threatens to destabilise the relationship between 'madness' narrative and reader. 'Madness' articulated beyond psychiatric discourse offers an entirely different perspective, liberating the 'mad' self from the limited and limiting pattern of taxonomy and instead moving it towards a state of linguistic 'free play'.[102] Cross contended that 'the expression of madness exceeds what is possible to talk about using conventional psychiatric discourse'.[103] Finding another semantic framework to communicate 'madness' would allow the experience to be liberated from a hegemonic narrative which has so little relevance but such an enduring influence on individual experience.

Published in 1892, Charlotte Perkins Gilman's *The Yellow Wallpaper* functions both as a scathing social commentary on the treatment of 'madness' – particularly in light of gender dynamics present in the text – and as a cathartic, semi-autobiographical narrative following Gilman's own contact with the psychiatric profession. Offering a first-person narrative and an intimate journal format, *The Yellow Wallpaper* grants insight into the internal monologue of the 'mad' narrator as she attempts to comprehend the self in defiance of psychiatric and patriarchal forces around her, and through this, the text offers alternative semantic frameworks to communicate the 'mad' self As with Poe's short story 'The Tell-Tale Heart', the reader immediately connects with the 'mad' narrator because the narrator, as the only available source of information, is an essential part of the reading process.

[102] Ingram, *Cultural Constructions*, p. 88.
[103] Cross, *Mediating Madness*, p. 29.

Although the narrator's experience of 'madness' is primarily articulated beyond hegemonic discourse, there is an intrusive psychiatric presence in the text. Both the narrator's husband and brother are 'physician[s] of high standing' (p. 10), who attempt to reduce the identity of the narrator to that of passive 'patient', despite her protestations. She performs the role of psychiatric subject – 'I take phosphates or phosphites – whichever it is, and tonics, and journeys, and air, and exercise, and am absolutely forbidden to "work" until I am well again' (p. 10) – without internalising it, as she actively defies John's instruction in secret. Despite writing being 'forbidden', the narrator seeks release and self-expression in the 'dead paper' (p. 10) of her journal, and reconstructs her identity in her own terms, hidden from John's gaze. In these pages, the narrator is able to undermine psychiatric hegemony: 'John is a physician, and *perhaps* […] – *perhaps* that is one reason I do not get well faster' (p. 10). She explains further: 'Personally, I disagree with their ideas […] I did write for a while in spite of them; but it *does* exhaust me a good deal – having to be so sly about it, or else meet with heavy opposition' (p. 10). The psychiatric conviction that 'madness' should be forced into the 'patient' role is portrayed as damaging, limiting. The narrator crafts a silent rebellion on 'dead paper' (p. 10): unable to articulate her resistance for fear of 'heavy opposition', she has found a self-forged space in which she can protect her identity and undermine John's 'authority'.

John is cautious of the narrator's capacity for self-expression, informing her that 'the very worst thing [she] can do is to think about [her] condition' (p. 10). Her identity is not hers to construct: it belongs to psychiatric hegemony, and thus she has no need for self-reflection or autonomy, lest it challenge the 'authority' of psychiatric discourse. The narrator's strong sense of self, and instinct for creativity, articulation and self-preservation, allow her to recognise her ability to manage her 'madness', as if she were allowed to 'write a little it would relieve the press of ideas and rest [her]' (p. 16). However, psychiatry – the 'heavy

opposition' – aspires to be the managing force, the 'master' of her 'madness'. Her domestic environment becomes a make-shift asylum, with her husband and his sister as her gaolers. The home has been reconstituted as a psychiatric space: 'the windows are barred for little children, and there are rings and things in the walls' (p. 12). Imprisoned in an improvised panopticon, she is forced into 'permanent visibility that assures the automatic functioning of [psychiatric] power'.[104] The narrator may resist psychiatry, but she is still subject to it.

Despite this, the narrator remains resolute in her sense of self, resisting 'otherness' by referring to her 'normal mind' (p. 25). Her narrative also stands as a testimony to, if not her 'sanity', then at least to her *coherent* 'madness'. Exerting control over her journal, managing her thoughts, the narrator composes her experiences in 'simple but tightly controlled prose which shifts, almost imperceptibly […] only at the very nadir of her psychosis'.[105] The uncanniness of the text does not lie in its unnerving portrayal of an 'alien' mental state, but in its ability to represent 'madness' in a way which makes it seem like the only possible 'sane' response. Trapped in a claustrophobic pseudo-asylum space, controlled and studied by her husband/physician, the narrator sees her 'madness' as her only chance for liberation from these governing forces.

The narrator, confined to the bedroom, creatively restricted and socially isolated, begins to observe the 'hideous […] unreliable […] infuriating' (p. 25) pattern of the yellow wallpaper which surrounds her. Initially, it is merely an object of aesthetic displeasure, a 'sprawling flamboyant pattern […] committing every artistic sin' (p. 13). But it soon becomes the focal point of the narrative, as the protagonist resolves to 'follow that pointless pattern to some sort of a conclusion' (p. 19). Using the maze of patterns as a form of mental 'gymnastics' (p. 19), the narrator imagines that she is able to move *in* the wallpaper, despite her physical confinement. It becomes a symbol of liberation, as Perkins Gilman establishes a

[104] Foucault, *Discipline*, p. 201.
[105] Wiesenthal, *Figuring Madness*, p. 24.

contrast between the 'sprawling' wallpaper (p. 25) and the immobility of the narrator ('I lie here on this great immovable bed – it is nailed down, I believe' (p. 19)).

The yellow wallpaper becomes a projection of the protagonist's interior state, externalised as a means of making sense of it.[106] It becomes a puzzle to be 'mastered' (p. 25), much like the narrator's desire to manage her own 'madness' away from the prying eyes of her psychiatrist/husband/gaoler. Symbolically, it is hers alone: 'no person touches this paper but me, - not *alive*!' (p. 33). When her other self becomes manifest in the paper ('that dim sub-pattern […] I am quite sure it is a woman' (p. 26), she is shielded from the psychiatric gaze: developing a self that is reconstructed beyond psychiatric 'authority'. This other self is fiercely protected: the narrator is 'determined that nobody shall find it out' (p. 27).

The narrator displays external signs of recovery – of what John terms 'flourishing in spite of [the] wall-paper' (p. 28) – although she discloses to her journal that it is '*because* of the wall-paper' (p. 28). To read the wallpaper as a metaphor for freedom is to shed significant light on the 'patient'/psychiatric dynamic. The other self in the wallpaper should, according to John, be a symptom of 'otherness' and illness. However, for the narrator, this projection of selfhood is an act of healing, of comprehending the self, of the potential for liberation despite the metaphorical straitjacket of her diagnosis and her claustrophobic marriage.

The narrator's ability to control her narrative – for the most part – allows her experience to remain accessible despite its deviation from established discourse of what 'madness' is. However, towards the end of the text, this control is jeopardised as it becomes irrelevant. Kristeva described the conflict between articulation and acknowledgement – the struggle both to speak and be heard:

> The narrative web is a thin film constantly threatened with bursting. For, when narrated identity is unbearable, when the boundary between subject and object is shaken, and when even the limit between inside and outside becomes uncertain, the

[106] This physical manifestation of internal distress is echoed in the literary device of multiple or other selves, which I will discuss shortly.

> narrative is what is challenged [...] its linearity is shattered, it proceeds by flashes, enigmas, short cuts, incompletion, tangles, and cuts [...] the unbearable identity of the narrator and of the surroundings that are supposed to sustain him can no longer be *narrated*.[107]

Kristeva was not implying, here, that 'madness' is ineffable, but that the narrative model – which must reach a social audience or reader in order to function as a narrative – has a finite capacity to communicate an experience which transcends hegemonic discourse. Towards the end of *The Yellow Wallpaper*, the narrative destabilises. Desperate to free her other self confined in the wallpaper, the protagonist begins to tear it off, and the sequence of events loses clarity:

> I don't like to *look* out of the windows even – there are so many of those creeping women, and they creep so fast.
> I wonder if they all come out of the wall-paper as I did?
> […]
> I suppose I shall have to get back behind the pattern when it comes night, and that is hard!
> It is so pleasant to be out in this great room and creep around as I please! (p. 35)

The literal limit between inside and outside is distorted; the identity of the protagonist is irrevocably blurred with her other self. The linearity of the text is splintered, and who is speaking and who is observing becomes ambiguous, or, in a sense, irrelevant. The narrator's identity becomes uncertain: multiplied, reflected, obscured. For the protagonist, this is a bid for power, and for liberation: freedom is achieved in a form of 'empowering and violent madness'.[108] However, her narrative defies Western assumptions that the self is 'unitary, individualised, permanent […] impermeable to spirituality and otherworldliness'.[109] By transcending this established discourse of selfhood, 'the unbearable identity of the narrator […] can no longer be *narrated*.'[110] 'The strange appears as a defense put up by a distraught

[107] Kristeva, *Powers*, p. 27. Emphasis in original.
[108] Showalter, *Female Malady*, p. 14.
[109] Lovell, 'City is My Mother', p. 355.
[110] Kristeva, *Powers*, p. 141.

self' and yet it is this strangeness – despite its urgency to be heard – which enforces the narrator's social position as 'other'.[111]

Perkins Gilman presents a narrative which primarily constructs 'madness' as a coherent and familiar state. 'Madness' is even portrayed as a justified response to the narrator's oppressive social conditions; it is the only way she can bid for creativity and autonomy in the face of psychiatric and patriarchal forces.[112] The narrator's 'madness' is one which literally overpowers psychiatry: the conclusion of the text reveals John 'fainted' (p. 36) at the sight of his wife who 'got out at last' (p. 36) – although the presence of the axe could imply something much more sinister. Her powerful declaration that 'you can't put me back!' (p. 36) subverts the 'patient'/psychiatrist dynamic: the narrator is the 'master' of her own 'madness', and psychiatric discourse has no purchase or control. Although the confusion and multiplication of selves present a barrier between 'madness' narrative and reader, the narrator can claim a victory nonetheless. The psychiatric narrative has been triumphantly rendered irrelevant, but its legacy – the assumption that 'mad' is 'other' – endures. The protagonist continues to move around the room despite John's presence, 'creep[ing] over him every time' (p. 36): psychiatric hegemony prevails, although it has been surpassed by the individual. It still must be negotiated, much like the narrator must alter her path to 'creep' over John's body.

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[111] Julia Kristeva, *Strangers to Ourselves*, trans. by Leon S. Roudiez (New York: Columbia University Press, 1991), p. 183.

[112] Academic Robert J G Lange observed that 'during the nineteenth century, it would have been considered "mad" [...] for a woman not to want to fulfil the traditional female role of wife and mother' (see Robert J. G. Lange, *Gender Identity and Madness in the Nineteenth-Century Novel* (Lewiston: The Edwin Mellen Press, 1998), p. 1). The narrator's struggle to be around her child – 'Such a dear baby! And yet I cannot be with him, it makes me so nervous' (p. 14), indicative of 'postnatal depression' – challenges the assumption that to be female is exhibit an unconditional maternal instinct. Her 'serious' thoughts 'of burning the house' (p. 29) reveal a desire to destroy her claustrophobic domestic environment, rather than embrace the role of homemaker. Therefore, it could be argued that the aetiology of the narrator's 'madness' – at least from the perspective of the patriarchal psychiatric forces around her – stems from her being something 'other' than a traditional wife and mother.

‘The Word “Lunacy” Was Never Employed’: Unconventional Semantics and Radical Politics in ‘The System of Doctor Tarr and Professor Fether’[113]

Another nineteenth-century text which foregrounds psychiatric narratives – and yet transcends them – is Poe’s short story, ‘The System of Doctor Tarr and Professor Fether’, published in 1845. The unnamed narrator represents the presence of alleged ‘sanity’ in an ‘insane’ place. During his travels, the narrator nears a ‘private Mad House, about which I had heard much, in Paris, from my medical friends. As I had never visited a place of the kind, I thought the opportunity too good to be lost’ (p. 266). ‘Madness’ is deemed a spectacle: an idea furthered by the reluctance of his companion, who pleads ‘a very usual horror at the sight of a lunatic’ (p. 266), and refuses to accompany him. The opening of the text demotes ‘madness’ to an object of ‘horror’, much like the role it primarily plays in ‘The Tell-Tale Heart’. By referring to this merging of ‘madness’ and horror as ‘very usual’, Poe is drawing attention to this reaction, thus forcing his reader to reflect. The first glimpse of the *maison de santé* is described in terms of the terror it provokes in the narrator: it ‘was a fantastic *château*, much dilapidated, and indeed scarcely tenantable through age and neglect. Its aspect inspired me with absolute dread’ (p. 266). However, having heard of the radical ‘system of soothing’ (p. 267) implemented, the narrator is overcome with curiosity.

The narrator introduces the reader to Monsieur Maillard – the man famed for creating the new ‘system of soothing’ – as ‘a portly, fine-looking gentleman of the old school, with a polished manner, and a certain air of gravity, dignity, and authority which was very impressive’ (p. 267). The notion of ‘authority’ is particularly salient, and it is something I will discuss in detail shortly. Maillard explains that the system he employs is founded on the following principles: ‘that all punishments were avoided – that even confinement was seldom

[113] Poe, ‘Tarr and Fether’, p. 269. All further references will be given in the main body of the text.

resorted to – that the patients, while secretly watched, were left much apparent liberty […] in the ordinary apparel of persons in right mind' (p. 267). The narrator thus takes it on himself to 'diagnose' the other characters he encounters, as there is no apparent demarcation between 'madness' and 'sanity'.

On meeting a 'young and very beautiful woman' (p. 267) whom Maillard later introduces as his niece, the narrator contemplates:

> I could not be sure that she was sane; and, in fact, there was a certain restless brilliancy about her eyes which half led me to imagine she was not […] She replied in a perfectly rational manner to all that I said; and even her original observations were marked with the soundest good sense; but a long acquaintance with the metaphysics of *mania*, had taught me to put no faith in such evidence of sanity. (p. 267)

Seeking any evidence to 'diagnose' her, he is convinced that her 'perfectly rational manner' and 'soundest good sense' are not absolute indicators of 'sanity'. There is something indefinably 'other' about her – much like psychiatrist Manfred Bleuler's description of 'madness' as 'totally strange, puzzling, inconceivable, uncanny' – although the narrator cannot quite detect what it is.[114] Rather than relying on the familiar trope of 'otherness' as a deviation from rationality (which the young woman could not be accused of, being 'perfectly rational'), the narrator describes 'a certain restless brilliancy about her eyes' which he interprets as reason to doubt her 'sanity'. However, this is not really a discourse which 'others' 'madness', which is, instead, portrayed as a force of energy and luminosity.

Immediately, the text blurs the boundaries between 'madness' and 'sanity', despite psychiatric and social hypotheses that such a distinction should be straightforward. The narrative then focuses on a dialogue between the narrator and Maillard, as the latter explains the mechanics of the 'soothing system' (p. 268):

> We contradicted *no* fancies which entered the brains of the mad. On the contrary, we not only indulged but encouraged them; and many of our most permanent cures have thus been effected […] We have had men, for example, who fancied themselves

[114] Sass, 'Introspection', p. 4. Wherever possible, I have gone to the original of all sources used. However, on occasion, despite thorough research, the original has not always been accessible.

> chickens. The cure was, to insist upon the thing as a fact – to accuse the patient of stupidity in not sufficiently perceiving it to be a fact – and thus to refuse him any other diet for a week than that which properly appertains to a chicken. (pp. 268-269)

Despite the obvious, dark humour throughout this passage, there is a crucially important undertone here: a suggestion that 'madness' does not have to be perceived as non-sense. It shows the potential for psychiatric discourse to be reconstructed around the idea that the 'fancies […] of the mad' do not have to be disregarded, but instead heard.[115] Maillard's system is based on the idea that the individual should dictate the treatment, rather than the treatment controlling – and governing – the identity of the individual.

Radically, Maillard, apparently representing psychiatric 'authority' (p. 267), explains how 'we affected to treat each individual as if for some ordinary physical disorder; and the word "lunacy" was never employed' (p. 269). Although the 'patients' are still removed from the social sphere and incarcerated, there are no straitjackets, no individual confinement, and – significantly – there is no need for taxonomy. No language is necessary to demarcate the 'patients' because they are not perceived as totally 'other': they represent a variant on 'sanity' but not its antithesis. The use of the past tense is significant, as Maillard explains that the system has been superseded, although he does not disclose any details about the new methods: he merely boasts that it 'is incomparably the most effectual as yet devised' (p. 269).

The narrator is invited to a dinner party with Maillard and 'a very numerous company' (p. 270) comprised of 'apparently people of rank – certainly of high breeding […] bedecked with a profusion of jewelry' (p. 270). Although there is something indefinably 'bizarre' (p. 271) about the atmosphere, the narrator dismisses it as his own cultural ignorance, musing: 'the world is made up of all kinds of persons, with all modes of thought,

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[115] Michael Stone recounted a similar anecdotal tale 'of a deluded prince […] in a distant land […who] had lost his mind and imagined himself a rooster' from the early nineteenth-century. The 'best physicians, the most famous specialists in the land' were unable to treat the prince, and 'admitted their incompetence'. A sage presented himself at court, and 'treated' the prince by indulging his belief that he was, indeed, a chicken. The prince returned to a performance of 'sanity' on the sage's advice: 'you can do anything with humans and even for humans and yet remain the rooster you are'. See Stone, *Healing the Mind*, pp. *xvii-xviii*.

and all sorts of conventional customs' (p. 271). Tolerant and apparently open-minded, and accommodating of 'conventional customs' which appear alien to him, it seems somewhat contradictory that the narrator should experience panic and alarm when he learns that he is breaking bread with a 'lunatic'. His immediate question – 'I take it for granted that she is not particularly – not dangerously affected, eh?'(p. 277) – reveals a latent prejudice which threatens to expose his veneer of liberalism.

The general talk at the dinner table preaches the humanity of 'madness', addressing individual experiences, rather than homogenised psychiatric constructs. The 'patients' are described beyond the terms of taxonomy, instead referred to as '*our* gentleman' (p. 272); 'a very singular genius' (p. 274); 'extraordinary personage' (p. 274) and 'a more sensible person [who] gave pleasure to all who had the honor of her acquaintance' (p. 275). The diverse range of human experience, liberated from limited and limiting psychiatric discourse, is celebrated. However, the reason for such tolerance is soon revealed, as the narrator realises that the 'set of reasonable people' (pp. 275-76) with whom he is socialising are, in fact, the 'patients'. Of course, this social microcosm must be 'mad' even to entertain the possibility that 'madness' can be viewed in human rather psychiatric terms. The narrator's 'nerves were very much affected' (p. 275) by this uncomfortable disclosure – a curious employment of psychiatric discourse which blurs notions of who and what it really applies to – but he continues to converse with Maillard, the 'authority' (p. 267), the epitome of reason against a backdrop of unreason.

Maillard finally begins to divulge details of the new system of treatment, explaining how it is 'agreeable' (p. 277) to the 'patients' despite the 'necessarily close' (p. 277) confinement it requires. He explains why the 'soothing system' had been rejected:

> The 'soothing system', you know, was then in operation, and the patients were at large […] the fellows behaved so *remarkably* well […] sure enough, one fine morning the keepers found themselves pinioned hand and foot, and thrown into the cells,

> where they were attended, as if *they* were the lunatics, by the lunatics themselves, who had usurped the offices of the keepers. (p. 279)

On the one hand, Maillard is depicting 'madness' as a devious force which must be controlled: the leniency provided by the 'soothing system' merely presented the 'lunatics' opportunity to display their latent 'cunning [and] dexterity' (p. 278) and orchestrate their escape. On the other hand, the literal inversion of keeper/lunatic – of psychiatrist/'patient', and of 'madness'/'sanity' – exposes just how tenuous these binary oppositions are.

Maillard then describes the desire of the 'head rebel' (p. 279) to coordinate a 'lunatic government' (p. 279), designed to 'overthrow […] the reigning powers' (p. 279). Not only providing a platform for a narrative that counters psychiatry, a 'lunatic government' – however metaphorical – harbours the potential to stage a revolution that literally overpowers psychiatry. It is an individual-focused narrative, rather than limited and limiting psychiatric discourse: created by the 'mad' for the 'mad', the apparent 'authority' of psychiatry is rejected, made irrelevant. It is no coincidence that the first act of this rebellion is to deconstruct the 'mad'/'sane' dichotomy by subverting it: it is exposed as an arbitrary process of demarcation.

The 'head rebel' (p. 279) becomes the 'master' of the psychiatric space, controlling admittance and 'othering' the keepers by tarring and feathering them until they resemble 'a perfect army […] of Chimpanzees' (p. 281). They are dehumanised, and made subject to the discourse which they enforced. The 'lunatic government' 'lived well' (p. 280) in their self-forged social microcosm, managing their own 'madness' once the reigning forces had been overthrown. Maillard – the 'authority' (p. 267) – comments that this new system was 'very capital […] simple – neat – no trouble at all' (p. 280), before the narrative is interrupted by a torrent of voices which reveal that 'the lunatics have most undoubtedly broken loose' (p. 280).

The violent altercation which follows – punctuated by the door being 'beaten with what appeared to be a sledgehammer […] wrenched and shaken with prodigious violence' (p. 280) – is enough for the narrator to comprehend what is really going on around him. The escaped 'lunatics' of 'prodigious violence' (p. 280) are, in fact, the keepers, who have broken free and are attempting to reclaim the psychiatric space. It is finally revealed that Maillard – the 'authority' (p. 267) – was indeed 'the superintendent of the establishment; but grew crazy himself, and so became a patient' (p. 281), instead taking on the role of 'head rebel' (p. 279) during the insurgence. When describing the 'lunatic government', he was 'merely relating his own exploits' (p. 281). Maillard's meandering identity – psychiatrist/'patient'/psychiatrist – is employed by Poe to expose just how fluid and haphazard such categories are. The narrative closes with a reinstatement of Maillard's 'authority' despite his 'madness', as the narrator reflects that 'I cannot help agreeing with Monseiur Maillard, that his own "treatment" was a very capital one of its kind. As he justly observed, it was "simple – neat – and gave no trouble at all"' (p. 282).

Although the confusion of 'madness'/'sanity' is enough to force the reader to question such problematic demarcations, Poe's commentary on psychiatric politics does not end there. A reader could interpret the chaos of the final scene as verification that 'madness' is inherently 'other' and should be treated as such:

> A scene of the most terrible confusion ensued […] the orchestra […] broke out, with one accord, into 'Yankee Doodle', which they performed […] with an energy superhuman, during the whole of the uproar. [T]he man with the tee-totum predilections, set himself to spinning around the apartment, with immense energy […] the frog-man croaked away […] the continuous braying of a donkey arose over all. (pp. 280-81)

The climax of the text depicts 'madness' as a form of carnivalesque pantomime: animalistic, raucous and absurd, it is the antithesis of reason and 'civilised' behaviour. It is also depicted as dangerous, as the narrator 'received a terrible beating' (p. 281), although the perpetrator of the act of violence, whether 'patient' or keeper, is – significantly – not revealed.

This melodramatic passage threatens to undermine Poe's subtle yet persistent insinuation that 'madness' does not have to be 'othered' and limited to psychiatric discourse. However, it is only after the appearance of the keepers – and thus the reinstatement of psychiatric hegemony – that 'madness' becomes 'other'. 'Madness' is a phenomenon of context: what is 'sane' in one situation (the scene at the dinner table, for example) can be perceived as 'insane' under the psychiatric gaze. The presence of the keepers instigates a parody of 'otherness' because that is all that psychiatry comprehends it to be. However, the structure of the story and narrative voice ensures that the reader has glimpsed 'madness' beyond the lens and language of psychiatry. Poe's 'reversal of reason and unreason [instigates] the reader's awareness of the arbitrary element structuring [of] such tactical oppositions'.[116] The fact that this 'element structuring' is the foundation of psychiatric language ensures that the enduring impression left in the mind of the reader is that hegemonic narratives are fallible. Psychiatric discourse is shown to condemn 'madness', rather than communicate it.

'Who in The World Am I?' Reading Other Selves and Other Worlds[117]

Neurologist and author Oliver Sacks, when reflecting on the medicalisation of hallucinogenic states, commented that 'hallucinations are more often considered to portend […] something dire happening in the brain […] there is great stigma here'.[118] Kraepelin described an hallucination as evidence of how 'profoundly disturbed' a 'patient' was.[119] Psychiatric discourse has established an experience of another 'reality' or another self as an anomaly – an unconventional way of experiencing the world which deviates from the 'norm' – to be condemned rather than understood. Hallucinations and multiple selves have become central

[116] Wiesenthal, *Figuring Madness*, p. 16
[117] Carroll, *Alice's Adventures*, p. 18.
[118] Sacks, *Hallucinations*, p. *xiv*.
[119] Kraepelin, *Dementia Praecox*, p. 7.

to psychiatric and therefore social conceptions of 'madness': psychiatric labels such as 'dissociative identity disorder' and 'schizophrenia' are founded on a point of departure from prescribed ways of viewing and understanding 'reality' and identity.[120] Psychiatric terminology relies on such states being viewed as 'other'.

But what if hallucinations and multiple experiences of selves were granted narrative space? What if they could be understood as alternative perspectives, rather than as total detachments from 'reality'? Literature, in creating a fictitious world and immersing the reader in it, is itself a form of hallucination, therefore the presumed 'otherness' of an hallucinatory experience is already challenged. An hallucination, described as 'entertaining unfounded notions', perfectly articulates the reading process.[121] The reader suspends disbelief and temporarily abandons notions of 'reality' in order to 'entertain' the 'unfounded notions' constructed by the imagination of the author. Fiction is, inevitably, a projection of the self. Although this interplay is not always explicit, 'the pathology of a literary character is often used to account for the pathology of its author'.[122] Fiction's primary function to 'hold […] the mirror up to nature' leads to an inevitable blurring of selfhood: the self (the author) constructs selves (the characters), an unavoidable manifestation of him or herself, to be interpreted by the reader, who understands the characters in terms of his or her own experiences of self, their ego-centred points of reference.[123] By distorting the real and the imaginary, and representing a myriad of selves as a *mise en abyme*, fiction challenges the 'otherness' of hallucinations and experiences of multiple selves before they are even

[120] Despite claiming to offer a 'natural history or anthology of hallucinations', Sacks distanced himself from the 'profoundly altered' experience of 'those with schizophrenia'. Although Sacks championed the 'power of hallucinations' and the value of 'first person accounts', a 'schizophrenic' hallucination was clearly deemed too 'other' for a popular science publication. Significantly, the synopsis of *Hallucinations* opens by assuring the reader that 'Hallucinations don't belong wholly to the insane'. See Sacks, *Hallucinations*, pp. *xiii-xiv*.

[121] *OED*, 'hallucination' <http://www.oed.com/view/Entry/83613?redirectedFrom=hallucination&> [accessed 16 September 2014].

[122] Martin S. Lindaver, 'Are Creative Writers Mad? An Empirical Perspective', in *Dionysus in Literature: Essays on Literary Madness*, ed. by Branimir M. Rieger (Bowling Green: Bowling Green State University Popular Press, 1994), pp. 33-48 (p. 33).

[123] Shakespeare, *Hamlet*, III. 2. 12-16.

represented in the text. It reclaims such states from the alienation imposed by psychiatry into the realm of the familiar, as a variant of 'reality' rather than its antithesis.

As fiction inherently obscures the binary oppositions of 'reality'/imaginary and fixed/permeable selfhood, it is unsurprising that it has been employed as a vehicle to explore and articulate experiences which fall between these apparently absolute binaries. Can literary representations of hallucinations and multiple selves reclaim them from the silence and 'otherness' enforced by psychiatry?

In rounding off this chapter, my chosen texts – Poe's short story, 'William Wilson' (1839); and Lewis Carroll's *Alice's Adventures in Wonderland* (1865) and *Through the Looking-Glass* (1867) – explore the point of departure from 'reality' and/or fixed perceptions of selfhood which dominates mainstream conceptions of 'madness'. In a similar fashion to *The Yellow Wallpaper*, other selves can be used to represent a physical manifestation of 'madness'. Unlike psychiatric discourse, however, which applies taxonomy to delimit the identity of the individual, these literary depictions demonstrate 'madness' to be one aspect of selfhood, rather than its entirety. 'Madness' is not always all-encompassing: it can be separated from the individual. By creating a self which represents a literal embodiment of 'madness', this doppelgänger becomes a mirror image through which the individual can study, understand and, ultimately, manage their interior state. This doubling can also be interpreted as a rebirth of the self after contact with psychiatry.

Elsewhere in his work, Poe relied on the doppelgänger as a literary motif to evoke a sense of the uncanny.[124] However, in 'William Wilson', this replication of selves becomes symbolic of the protagonist's desire to comprehend his own 'madness'. Wilson's narrative begins with a sense of despair, instigated by social exclusion: 'Oh, outcast out of all outcasts

[124] This trope features heavily in, for example, 'The Fall of the House of Usher'.

most abandoned – to the earth art thou not forever dead?'[125] Mirroring psychiatric discourse, he discloses to the reader that he is 'the descendant of a race [with] imaginative and easily excitable temperament […] weak-minded, and beset with constitutional infirmities' (p. 67). Wilson can only articulate his experiences in terms of 'otherness', as it is the only discourse available in popular currency: he has no other language. However, the emergence of his doppelgänger grants him a new perspective on his 'madness'. Wilson's double is undoubtedly an externalisation of the self: 'The same name! the same contour of person! the same day of arrival at the academy! And then his dogged and meaningless imitation of my gait, my voice, my habits and my manner!' (p. 75). This other (and, indeed, 'other') self offers an alternative to psychiatric discourse as the foundation for his narrative and his identity.

Wilson's double becomes a projection of his apparent 'otherness'. Reluctant to internalise it, Wilson creates a new self who can *be* 'other' so he can remain familiar: the double becomes Wilson's 'madness', allowing him to detach himself from it. However, Wilson's double shoulders the burden of 'otherness' so that Wilson can remain part of mainstream society. The double is silenced – unable to raise his voice '*above a very low whisper*' (p. 72, emphasis in original) – because psychiatric discourse has stifled his narrative, declared it a 'closed' text. The 'mad' Wilson's presence in the text wanes, portraying 'madness' as a transient and fluctuating state, but his final reappearance at the end of the narrative serves to reintegrate the two selves. Although 'other', the 'mad' Wilson represents 'omnipresence and omnipotence' (p. 82): he is empowered, as this separation of selves grants one a voice at the expense of the other's silence.

Similarly, Carroll's *Alice's Adventures in Wonderland* and *Through the Looking-Glass* make 'othered' states tangible and familiar. These texts explore hallucinogenic

[125] Edgar Allan Poe, 'William Wilson', in *Selected Tales,* ed. by David Van Leer (Oxford: Oxford University Press, 1998), p. 66. All further references will be given in the main body of the text.

experiences through the presence of an alternative world in which the protagonist is immersed. This universe exists through the looking-glass, 'the glass has got all soft like gauze, so we can get through', merging ideas of selfhood by displaying the potential for the mirror to present not just the self but *selves*: not just the world but *worlds*.[126] Rather than reflecting and thus reinforcing Alice's identity, the microcosm in the looking-glass fractures and distorts the self: '"Who are *you*?" said the Caterpillar […] Alice replied, rather shyly, "I-I hardly know, Sir, just at present […] I ca'n't [*sic*] explain *myself* […] because I'm not myself"'.[127] Alice's hallucinatory experience is initially disorientating, and she struggles to anchor the self in the strange world around her. The vivid and bizarre wonderland is an embodiment of her 'madness': it is a place to which she has access only because of her 'madness'. The Cheshire Cat informs her that she must be 'mad' 'or you wouldn't have come here'.[128] Her alternative experience of 'reality' has literally opened up new worlds, and new perspectives, and eventually it functions as a space in which her identity can be reconstructed and self-governed.

Alice's wonderland is a space in which her 'madness' can be *hers*, to explore and to understand, divorced from psychiatric discourse. This image echoes earlier ideas of 'madness' as a state of creativity and knowledge which surpasses mainstream consciousness. In this world, created by and for the self, language becomes malleable: it is destabilised in order to accommodate the self. Humpty Dumpty observes:

> 'When *I* use a word,' Humpty Dumpty said, in rather a scornful tone, 'it means just what I choose it to mean – neither more nor less.'
> 'The question is,' said Alice, 'whether you *can* make words mean so many different things.'
> 'The question is,' said Humpty Dumpty, 'which is to be master – that's all'.[129]

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[126] Lewis Carroll, *Through the Looking-Glass*, ed. by Roger Lancelyn Green (Oxford: Oxford University Press, 2008), p. 127.
[127] Carroll, *Alice's Adventures*, pp. 40-41.
[128] Carroll, *Alice's Adventures*, p. 58.
[129] Carroll, *Looking-Glass*, p. 190.

Humpty Dumpty exposes language in a Saussurean vein as merely a construct – a system that can therefore be *de*constructed to contain the individual experience. Humpty Dumpty is the 'master' of language: it becomes a tool at his disposal, which he can make 'mean just what I choose it to'.[130] Despite this semantic power, he does not represent hegemony because he encourages Alice to 'master' language in turn: a Saussurean apprenticeship. Alice's self-contained, self-created world allows her to be the 'master' of her 'madness' because the self is reconstructed beyond psychiatric discourse. She makes sense of her 'madness' on her own terms, rather than through taxonomy. If Alice's hallucinatory discourse can become socially accessible, it can function as a counter-narrative. If psychiatry's power is destabilised by this counter-narrative, then there is potential for the 'mad' individual to reclaim 'mastery' of language: not by conforming to it, but by recreating it.[131] Language is not inherently a psychiatric weapon: the prison-house of language can, instead, be a wonderland – it can belong to the individual, rather than function as a device used solely to demarcate and condemn.

These depictions of other selves and hallucinatory experiences are inevitably 'other' because they transcend 'the Western conception of the person […] organized into a distinctive whole'.[132] However, both the nature of the literary form (which blurs apparently fixed ideas of 'reality'/the imaginary, the self/selves) and the accessibility of such experiences intimate that this 'otherness' does not necessarily have to induce silence. Far

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[130] Carroll's playful approach to 'mastery' of language could reflect his own tumultuous relationship with conventional language as, according to literary biographer Roger Lancelyn Green, due to an 'incurable stutter', Carroll sought the less judgemental company of children – enjoying 'freedom in the society of children' – which resulted in 'unusually deep knowledge of their modes of thought and imagination'. See Roger Lancelyn Green, Introduction, in Lewis Carroll, *Alice's Adventures in Wonderland* and *Through the Looking-Glass* (Oxford: Oxford University Press, 2008), p. *xxi*.

[131] *Alice*'s preoccupation with 'madness […] freedom and rules, authority and identity' inevitably offers a commentary on how the self is constructed – and can be 'othered' – using language (see Hugh Haughton, Introduction, in Lewis Carroll, *Alice's Adventures in Wonderland* and *Through the Looking-Glass* (Penguin: London, 2003), p. *lx*. This focus, combined with Carroll's representation of hallucinogenic states, offers a commentary on 'madness' by virtue of representing it. When the Cheshire Cat claims that 'we're all mad here. I'm mad. You're mad' (p. 58), Carroll cannot avoid exploring what it *means* to be 'mad', or at least *labelled* 'mad'.

[132] Sass, 'Introspection', p. 1.

removed from psychiatric discourse which granted 'madness' narratives space merely to apply taxonomy, demonstrate anomalies and enforce alienation, these literary representations encourage the reader to immerse themselves in these 'other' experiences. The hallucination of the 'mad' self or selves becomes the hallucination of the reader.

'We *Can* Talk […] When There's Anybody Worth Talking To': That Which Still Remains Unspoken[133]

I have shown that the literature of the nineteenth century provided 'madness' with a voice. Rescued from the disenfranchisement of psychiatric texts, the 'madness' experience could present itself to mainstream society in a literary narrative in order for it to be heard. Such literature employed a variety of semantic patterns through which 'madness' could be constructed, both in and beyond hegemonic discourse. Psychiatric terms and concepts, and the prevalent assumption that 'madness' is a state of unreason, of violence, of 'otherness', were a familiar trope in nineteenth-century literature, used as a foundation to communicate 'madness' in a socially familiar way. However, by exposing the fallibility of such language – by juxtaposing the psychiatric construction of 'madness' with individual experience – such texts challenge the very narrative they employ. Literature cannot represent 'mad' as 'other' without inevitably portraying the agencies that work to enforce marginalisation, and thus the 'authority' of psychiatry is thrown into question because the reader is encouraged to be an active entity in this debate.

The inclusion of a psychiatric presence – such as the characters of Dr Mosgrove, Dr Seward, and John in *The Yellow Wallpaper* – allows for texts to ventriloquise psychiatric narratives while also exposing their arbitrary and flawed assumptions. The 'authority' of Seward, for example, is challenged as the plot is stalled due to his inability to heed Renfield's

[133] Carroll, *Looking-Glass*, p. 138.

wisdom. The two characters are merged throughout the text to demonstrate how thin the dividing line is between the epitome of 'sanity' and reason (the psychiatrist) and the 'homicidal maniac'.[134] Mosgrove, although initially sympathetic to Lady Audley's situation, is portrayed as corrupt, incarcerating her despite declaring her 'sane'. John's domestic sphere acts as an improvised asylum which oppresses his wife, who merely desires a creative outlet to 'relieve the press of ideas and rest me'.[135] Psychiatry – the supposed 'authority' on 'madness' – is deemed to be out of touch with it: its ideas are exposed as having little or no application to the individual. The 'mad' self survives and narrates *despite* psychiatry, not because of it.

Further, far from being a haven of moral management and a place of 'cure', the psychiatric space is repeatedly portrayed as a premature burial: a purgatorial life/death, absent/present state. From the 'shallow grave'[136] which detains the narrator in 'Maud', to Lady Audley's contention that 'you have brought me to my grave': this persistent image of being buried alive is particularly uncomfortable.[137] It suggests the inevitable 'social death' which the individual experiences once psychiatric 'authority' allocates the role of 'patient'.[138] It also forces the reader to reflect on the reality (albeit fictionalised) of asylum life. Is the asylum really the *just* space for the 'mad' if it is not a place of compassion and 'cure' but merely a 'literal "shutting up"'?[139]

Literature also allows hegemonic narratives to be superseded, as the expectation of poetic licence allows for the formulation of an alternative relationship with language and expression: the self can be constructed beyond the realm of psychiatric terminology. This transcendence of the governing discourse allows 'madness' to be portrayed as a creative,

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[134] Stoker, *Dracula*, p. 68.
[135] Perkins Gilman, *Yellow Wallpaper*, p. 16.
[136] Tennyson, 'Maud', II. V. I. l. 6.
[137] Braddon, *Lady Audley's Secret*, p. 391.
[138] Kleinman, *Illness Narratives*, p. 26.
[139] Cross, *Mediating* Madness, p. 23.

spiritual force: a state of knowledge which directly contradicts psychiatric assumptions. Perkins Gilman, for example, was able to construct a new semantic pattern to discuss 'madness' by implying that it could be something other than 'other'. However, the chaotic blurring of selves at the end of *The Yellow Wallpaper* rendered the text inaccessible. The narrator of *The Yellow Wallpaper* found herself 'shut […] up in Prose', let down by her narrative model.[140] As Kristeva observed, 'the unbearable identity of the narrator […] can no longer be *narrated*' when the linearity and coherence of the text are jeopardised.[141]

Finally, literature can also be a medium which surpasses the 'us' and 'them' dichotomy by celebrating diversity of human experience, rather than condemning it. By guiding the reader through experiences of multiple selves and hallucinatory states, the *strangeness* of 'madness' is made available to the reader, rather than kept at a 'safe' distance. This allows the reader vicariously to experience these states, and, consequently, they are no longer 'other': deemed as variants of 'reality', these discourses threaten to undermine 'the social invalidation of such experiences' which psychiatry encouraged.[142]

Despite offering an accessible medium for articulating and exploring selfhood, literature cannot escape the tumultuous relationship between 'madness' and language. Paradoxically, each text featured in this chapter uses language to make reference to the ineffability of 'madness'. Although literary narratives offer a voice and the potential for new semantic structures, 'madness' resists articulation: language is inadequate or irrelevant, 'the words don't *fit*'.[143]

A Foucauldian interpretation would suggest that this evasion of language is merely the nature of 'madness': 'it cannot be expressed in any speech, no limit to such modes of

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[140] Emily Dickinson, '613', in *Emily Dickinson Everyman's Poetry*, ed. by Helen McNeil (London: Everyman, 1997), l. 1.
[141] Kristeva, *Powers*, p. 27.
[142] Mary Barnes and Joseph Berke, *Mary Barnes: Two Accounts of a Journey Through Madness* (Harmondsworth: Penguin, 1973), p. 84.
[143] Carroll, *Alice's Adventures*, p. 108. Emphasis in original.

expression can be grasped'.[144] 'Madness' defies orthodox language because the process of signification is too absolute, too rigid to allow for malleability: conventional vocabulary has no purchase. As William Wilson asks 'what human language can adequately portray that astonishment, that horror?'[145] Although the form may be accommodating, the language is not: reducing 'madness' to a limited and limiting frame of conventional vocabulary is merely what David Cooper termed the 'perpetual slipping over of words'. [146]

The absence of adequate and neutral language continues to deprive 'madness' of a narrative vehicle which can *truly* articulate the experience, and therefore provide society with an authentic semantic frame in which it can be communicated. If a verbalised 'madness' narrative cannot avoid censorship, distortion or stigma, what is the alternative? For those desperately requiring a voice but unable to negotiate the politics of language, what is the solution? It is to non-linguistic forms of communication that this thesis next turns.

[144] Foucault, *History of Madness*, p. 31.
[145] Poe, 'William Wilson', p. 83.
[146] Cooper, *Language of Madness*, p. 20.

CHAPTER FOUR

From the 'Meaningless' to the Mythologised: 'Madness' Narratives and Art[1]

I have exposed the politics and problems inherent in the employment of language to construct and communicate an experience of 'madness'. Language is an insurmountable barrier: it is a tool used to 'other' and disenfranchise, yet it is relied on for narration and social engagement. 'Madness' lies in a purgatorial state between the spoken (the existing psychiatric discourse which provides a limiting and damaging lexical framework for 'madness' narratives) and that which cannot be heard (narratives which transcend hegemonic discourse but which are unable to reach, or engage, a social audience). A semantic account of 'madness' cannot be neutral, as it is either couched in psychiatric language (which denotes the individual as a 'patient' and restricts identity to an arbitrary label), or it is received as irredeemably 'other' (because it rejects or ignores hegemonic discourse).

A 'madness' narrative constructed by language cannot escape this conflict: to verbalise 'madness' is to enter this battleground, reluctantly or otherwise. Until there is change, there will be silence. In chapter five, I discuss the necessity for this change but, in this present chapter, I explore the viability of alternative narrative forms: those which transcend semantics and avoid being dragged into the inescapable politics of language. Continuing my primary focus on nineteenth-century texts, this chapter will explore the work of artists experiencing 'madness' in order to establish the extent to which these narratives can be acknowledged and accepted by a mainstream audience. American philosopher John Dewey believed that, although visual art is 'a language', it offers a less rigid – and thus more

[1] Prinzhorn, *Art of Insanity*, p. 64.

accessible – structure in which a narrative can be constructed.[2] Dewey argued that art is the only medium 'of complete and unhindered communication' which could offer a solution to the 'madness' and language problem which has historically enforced silence.[3]

In order to cover a variety of texts, I have chosen to focus on the work of both canonical and less familiar artists. My only criterion is that the individual has experienced – or has been told they experience – a form of 'madness' in the course of their lives. I have narrowed my focus down to the following six artists: Richard Dadd (1817-1886); Vincent Van Gogh (1853-1890); Louis Wain (1860-1939); Adolf Wölfli (1864-1930); August Klett (given the pseudonym 'August Klotz' by Prinzhorn, 1864-1928); and Hyacinth Freiherr von Wieser (granted the pseudonym Heinrich Welz by Prinzhorn: born in 1883, year of death unknown).[4] All of these artists had contact with psychiatry and asylum culture, with periods of incarceration ranging from twelve months (Van Gogh) to forty-three years (Dadd). Diagnoses range from 'schizophrenia' to 'generalised delirium'. However, despite these contextual differences, their art has a common strand: the artists use it as a narrative platform to communicate their experiences, and so an analysis of it can illuminate the fraught relationship between a 'mad' self, 'reality' and mainstream society. My methodology in approaching 'mad' art is both to acknowledge how such texts are interpreted by a mainstream audience, and to unpick the politics which influence and manipulate this response.

In order to investigate the place of 'mad' art in the broader art world, it is necessary to ascertain what the standard of art was for nineteenth-century artists. What criteria did one need to fit to be an Artist? A brief excursion into the ideologies and exhibitions of the Royal

[2] Dewey, *Art as Experience*, p. 110.
[3] Dewey, *Art as Experience*, p. 109.
[4] Although there is geographical diversity between my chosen artists, all were subject to the same overarching psychiatric discourse. Michael Stone described how this discourse was homogenised across Europe: nineteenth-century British psychiatric 'developments' were 'occurring [elsewhere] on the continent', with the likes of France, Germany and Britain all witnessing 'the same […] movements'. Stone, *Healing the Mind*, p. 104.

Academy of Arts can be used to establish canonicity: from this, the relationship between 'mad' art and the broader art world can be further explored.

The Royal Academy was established by architect Sir William Chambers, who petitioned George III in 1768 to be allowed to 'establish a society for promoting the Arts of Design'.[5] Dedicated to publicising the art of its Academicians, the Royal Academy inaugurated a tradition of annual exhibitions: the first Royal Academy Summer Exhibition opened in 1769, and, to the present day, has been held every year since without exception. One of the founders of the Royal Academy, influential English painter Joshua Reynolds, expressed how the establishment of the Academy was 'in the highest degree interesting, not only to the Artists, but to the whole nation'.[6] The popularity of these exhibitions with the general public was recorded when a writer for *The New Sporting Magazine* observed how 'the rooms [in the exhibition] were most unpleasantly crowded' due to the sheer volume of visitors.[7]

Historian Holger Hoock reflected on the role academies played in circulating and standardising art: '[they] affect artists and art through education, competitions, and exhibition spaces; by mediating between artists […] and public opinions; and *by setting and enforcing standards* of taste and professional practice'.[8] Hoock's argument that the Royal Academy served to establish expectations of what art was is echoed in art historian Jason Rosenfeld's claim that the Royal Academy had 'virtual monopoly on public taste'.[9] If the Royal Academy were responsible for 'forging a native artistic tradition', how did their exhibitions shape the

[5] Information taken from the Royal Academy of Arts, 'About Us' <https://www.royalacademy.org.uk/about-the-ra> [accessed 12 February 2016].
[6] Joshua Reynolds, quoted in Holger Hoock, *The King's Artists: The Royal Academy of Arts and the Politics of British Culture 1760-1840* (Oxford: Oxford University Press, 2003), p. 1.
[7] Anon, 'Exhibition at the Royal Academy', *The New Sporting Magazine*, June 1837, Vol. XII, No. 74.
[8] Hoock, *King's Artists*, p. 3. Italics added for emphasis.
[9] Jason Rosenfeld, 'The Salon and The Royal Academy in the Nineteenth Century', October 2004 <http://www.metmuseum.org/toah/hd/sara/hd_sara.htm> [accessed 12 February 2016].

social expectations of what art *is*, and *should be*?[10] What standards were being set for canonical art by the 'professional ideology' of institutional art?[11]

In 1847, the Royal Academy relocated their exhibition space from Somerset House, located in the Strand, to a new site in Trafalgar Square. In light of this relocation, press interest had peaked, and the exhibition was covered in meticulous detail by popular periodicals and magazines. The overarching theme of these reviews is the search for truthful representation. A writer for *The New Sporting Magazine* praised the level of realism on display: 'these pictures are all painted with great power and truth […] the modesty of nature is never sacrificed for the sake of effect. The colours are pure'.[12] A review in *The Spectator* discussed the 'national excellence' on show, commenting how this 'excellence' 'consists mainly in the power of imitating'.[13] *The Gentleman's Magazine* commended the work of Sir Edwin Henry Landseer in particular, describing his representation of animals as 'perfect'.[14] *The Literary Gazette* championed the 'fidelity' of the art exhibited, describing how the subject matters were 'very naturally portrayed'.[15]

Simultaneously, these reviews critique details of work which did not match this trend for imitative art. Two of Edwin Landseer's pieces – depicting falcons – were disparaged: 'the eye of the bird […] seems rather too quiet; and the plumage of both birds is too much like smooth silky fur'.[16] *Spaniel and Game* by A. D. Cooper also failed to live up to the realism exhibited elsewhere: 'the leaves of the fir tree appear too sooty, and the hare rather too

[10] Hoock, *King's Artists*, p. 10.
[11] Hoock, *King's Artists*, p. 306.
[12] Anon, 'Exhibition', *New Sporting Magazine*.
[13]Anon, 'Exhibition of the Royal Academy', *The Spectator*, 27 May 1837, pp. 498-99 (p. 498).
[14] Anon, 'Fine Arts: Exhibition of the Royal Academy', *The Gentleman's Magazine*, June 1837, pp. 70-74 (p. 72). The 1847 exhibition featured a handful of Landseer's work, including *The Highlands* and *Return from Hawking*. Landseer's legacy as an artist endures: perhaps his best-known work is the four large bronze lion sculptures which guard Nelson's Column in Trafalgar Square.
[15] Anon, 'Fine Arts: Exhibition of the Royal Academy Second Notice', *The Literary Gazette*, 6 May 1837, pp. 314-15 (p. 314).
[16] Anon, 'Exhibition', *New Sporting Magazine*.

light'.[17] The Royal Academy's celebration of art which is 'beautifully true' encouraged its audience to challenge work which did not match this expectation: that which was considered accomplished art 'imitate[d] to perfection'.[18] The 'aesthetic authority' and hegemony of the Royal Academy enforced standards of what art should be to the extent that when reviewers were discussing the credibility and merit of the art on show, the primary criterion was its ability to imitate the subject matter flawlessly.[19]

This assumption that art should be realistic was not a new concept in the nineteenth century: Plato observed how the 'correctness' of art 'lies in the imitation and successful reproduction'.[20] If an audience solely expects art to imitate, this threatens to render 'mad' art inaccessible. If art does not represent something familiar, if it offers a new or alien perspective of 'reality' or human experience, then it is unable to imitate. Something 'other' – which transcends orthodox understandings of the self – cannot be classed as imitative art: it is not 'the action or practice of […] copying' because the object being reproduced (lived experience of 'madness') is not universally *known*.[21] The historic practice of silencing the individual experience of 'madness' continues: because 'madness' narratives are not socially acknowledged, they remain unspoken. Because they are unspoken, they are unfamiliar, and thus 'mad' art is excluded from this tradition of imitative art. This trend for realism would suggest that there is little place for anything 'other' in the canon of the art world: it must reproduce that which is known, rather than delving into the world of the unfamiliar.

However, Turner prize-winning artist Grayson Perry identified a shift in the mid-nineteenth century which complicated orthodox understandings of what art was, and how it should be approached. Describing this change as a rise in self-consciousness, Perry argued

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[17] Ibid.
[18] Anon, 'Exhibition', *Spectator*, p. 498.
[19] Hoock, *King's Artists*, p. 300.
[20] Plato, *The Laws*, trans. by Trevor Saunders (London: Penguin, 2005), p. 63.
[21] *OED*, 'imitation' <http://www.oed.com/view/Entry/91777?redirectedFrom=imitation#eid> [accessed 22 January 2015].

that 'the definition of art started being challenged'.[22] Expectations and interpretations of art were becoming less absolute, as documented by Russian philosopher and novelist Leo Tolstoy in 1897: 'art is becoming something more and more vague and indefinite in people's minds'.[23] This was exemplified by the rise of 'alternate exhibition venues [which] challenged the […] hegemony' of the Royal Academy and other esteemed academies[24], and growing criticism of artistic institutions which 'failed to represent all genre, media, and styles of "national art"'.[25] By the end of the century, 'the utopia (or dystopia) of aesthetic experimentation' eventually paved the way for the rise of Modernism, Surrealism, Abstract Expressionism, and the Art Brut/Outsider Art movement.[26]

The trend for art which 'imitated to perfection'[27] gradually declined: Tolstoy explained how 'people will understand the meaning of art only when they cease to regard beauty – that is, pleasure – as the aim of the activity'.[28] In the mainstream art world of the late nineteenth-century, Realism gave way to increasingly abstract trends, such as Impressionism, Post-Impressionism and Expressionism. Beauty and imitation – being 'beautifully true' – were no longer deemed the sole purpose of art.[29] Previously, canonical art had been a self-referential rhetoric – particularly in the elite microcosm of academy culture – which presented the *beautiful* because it was the *expected* and the *expected* because it was the *familiar*. Perry observed that 'beauty [was] very much about familiarity, reinforcing an idea we have already'.[30] However, instead of art's primary focus being representation with the 'greatest fidelity' – a trope championed by the Royal Academy and the Salon – expectations

[22] Grayson Perry, *Playing to the Gallery* (London: Penguin, 2014), p. 71.
[23] Leo Tolstoy, *What is Art?*, trans. by Richard Pevear and Larissa Volokhonsky (London: Penguin, 1995), p. 8.
[24] Rosenfeld, 'Salon'.
[25] Hoock, *The King's Artists*, p. 299.
[26] Sander Gilman, 'The Madman as Artist: Medicine, History and Degenerate Art', *Journal of Contemporary History*, 4 (October, 1985), 575-97 (p. 581).
[27] Anon, 'Exhibition', *Spectator*, p. 498.
[28] Tolstoy, *What is Art?*, p. 35.
[29] Anon, 'Exhibition', *Spectator*, p. 498.
[30] Perry, *Playing*, p. 14.

of art were broadening.[31] On the horizon of the *fin de siècle*, there were a growing number of mainstream movements that established art as medium of experimentation through which variants of human experience and emotion could be explored.

These changing perceptions of art championed ideas of innovation and *de*familiarisation over schools of realism and imitation: Modern art is now valued by its originality rather than its ability to represent something known.[32] Perry elaborated further, dismissing anything which is 'a boring version of something else' as *non* or failed art.[33] This is reminiscent of Modernism's call to 'make it new', as 'the old models were thrown out. Function defined form'.[34] By dismissing the 'old models' – traditional perceptions and patterns of art – there is potential that the 'old models' of understanding the self could also be 'thrown out' in favour of diversity, along with the 'old masters'. 'Madness' defamiliarises: it offers new and alternative perspectives on the world, selfhood, and 'reality'. Art movements such as Outsider Art, Post-Impressionism and Modernism which champion 'function' (art as a form of communication) over 'form' (being 'beautifully true') could offer a sustainable platform for 'madness' narratives.[35] Indeed, as Tolstoy argued, 'the only true work of art is one that conveys a *new* feeling (however insignificant) into the general usage of human life'.[36]

Were Tolstoy correct, these broadening expectations of art would offer not only a voice to the individual experience of 'madness', but might also allow this alternative representation to enter 'general usage', thus challenging hegemonic narratives. According to

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[31] Anon, 'Exhibition', *New Sporting Magazine*. The Salon was the official art exhibition of the Académie des Beaux-Arts in Paris.
[32] My use of the term 'defamiliarisation' here and elsewhere refers to the artistic process 'of rendering unfamiliar'. See *OED*, 'defamiliarisation' <http://www.oed.com/view/Entry/48712?redirectedFrom=defamiliarisation#eid> [accessed 12 February 2016].
[33] Perry, *Playing*, p. 61.
[34] J. G. Ballard, 'A Handful of Dust', *The Guardian*, 20 March 2006 <http://www.theguardian.com/artanddesign/2006/mar/20/architecture.communities> [accessed 22 January 2015].
[35] Anon, 'Exhibition', *Spectator*, p. 498.
[36] Tolstoy, *What is Art?*, p. 59. Italics added for emphasis.

Tolstoy, art is concerned with 'making understandable and accessible that which might be incomprehensible', and so there is potential for it to articulate 'madness' without simultaneously rendering it 'other' and mute.[37] However, considering the complex politics involved with verbalising 'madness', it does seem a little naive to assume that visual art offers a simple alternative. In addition to the changing perceptions of the nature and the construction of art, we must also consider the other, perhaps most problematic, variable: social reception.

The idea that art could be 'a communicator of uncovered deep determinants of human behaviour' suggests that movements such as Outsider Art and Symbolism not only offered radical understandings of what art could be, but also reflected and revealed different ways of perceiving the self.[38] The audience were presented with a narrative which not only offered an alternative experience of 'reality', but which also, potentially, explored universal ideas of human identity.[39] Although audience engagement offers the possibility of connection and empathy, the text (in this case, the piece of visual art) is both received and inevitably reconstructed by the viewer. The eye of the viewer 'selects, organises, discriminates, associates, classifies, analyses, constructs. It does not so much mirror as take and make'.[40] A 'madness' narrative – expressed through art – escapes the gaze of the psychiatrist, only to be 'classified' and 'analysed' by the viewer instead. Although 'symbols are media of communication', they are also vulnerable to misunderstanding and deconstruction: in an attempt to relate to a piece of art, the viewer is likely to reinterpret the image in order to allow it to fit with their experience of identity, or 'reality'.[41] Art offers no paratext, no preface:

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[37] Tolstoy, *What is Art?*, p. 121.
[38] Vernon McKay and Marjie L. Baughman, 'Art, Madness and Human Interaction', *Art Journal*, 4 (Summer, 1972), 413-20 (p. 418).
[39] This changing nature of art allowed art which was traditionally marginalised by the hegemony of the academy to be viewed beyond its 'otherness', thus – in theory – preventing its immediate dismissal. This opened up the potential for art to be considered what Thelmar termed a 'Human document' – having credibility by virtue of representing human experience, rather than being art which should be judged merely on its ability to imitate.
[40] Nelson Goodman, *Languages of Art* (Indiana: Hackett, 1976), pp. 7-8.
[41] Goodman, *Languages*, p. 257.

there is room for introduction (in the form of a title) but, other than that, the image must hold its own. The artist has little control over social interpretation.[42] 'The eye comes always ancient to its work', and therefore different perspectives and receptions are inevitable.[43]

The variables here are endless: we are influenced, for example, by our experience; our identity (or our perceptions and assumptions of selfhood); our mood; the context in which we view the image; the information we are given about the artist (or have absorbed by social osmosis); or our relationship with the art world more generally. When one approaches the work of Van Gogh, for example, one may recall the infamous anecdote about his self-mutilation, and thus the reception of the text is inevitably altered by this pre-existing knowledge. When encountering art in Prinzhorn's *The Art of Insanity*, the viewer's interpretation is coloured by context. If we are told a piece of work belongs to a certain genre, we may respond differently: we might have decided we prefer Realism and so respond negatively to something abstract (or vice versa). Someone ignorant of Louis Wain's earlier work may celebrate the originality and vibrancy of his art, without being aware of the radical shift in style which coincided with his incarceration. How can 'mad' art be understood as a vitally important bid to be *heard* when it is subject to dismissal due to something as trivial as *taste*?

When approaching 'mad' art, we are also exposed to an enduring social cliché which marries creativity and mental illness, and which dates as far back as Aristotle. He mused that 'melancholy is due to their [the 'melancholic'] responding too quickly to the imagination', reflecting an assumption that the 'mad' artist is expected to exhibit heightened senses and

[42] Of course, this is not a phenomenon unique to visual art: a literary text is also susceptible to the reinterpretation of the reader. However, as a general rule, due to form, the connection between audience and visual art can be fleeting – perhaps limited to a glimpse – and this sense of immediacy can render the art/audience relationship particularly fragile. By comparison, a literary text – even something fairly short such as a poem – requires relatively prolonged engagement on behalf of the reader: the literary text has to be *read*, whereas visual art can be *seen*. This makes immediate dismissal less likely, as the reader – by virtue of *experiencing* the text – is invested in it.

[43] Goodman, *Languages*, p. 7.

creativity and, above all, artistic and technical ability.[44] It may seem obvious to expect artistic ability from artists, however, in order to consider the credibility of art as a universal narrative model, there are two forms of accessibility which need to be considered.[45] It is vital that the text is made accessible to a social audience in order to render the narrative process complete. However, this is of little use if the individual is not able to use art to construct a narrative as they are not deemed to display technical artistic ability, an admittedly arbitrary criterion and, again, one subject to audience interpretation. It is expected that the 'mad' artist 'sees more deeply and is able to articulate this perception': this stereotype imposes itself onto the viewer.[46] Anticipating a grand, complex masterpiece which will offer insight into the intense creativity and 'alien' mind of the 'madman', a viewer may be disappointed and thus dismissive of Wieser's stark sketching or Wain's cartoonish anthropomorphism.

The anti-psychiatric movement further reinforced ideas of 'madness' and heightened creativity: Laing explained how 'the ['mad'] self […] is free to dream and imagine anything […with] unconditioned freedom, power, creativity'.[47] This movement saw 'madness' as a creative response to the world, and this point of departure from 'sanity' was encouraged, rather than oppressed. The case of English artist and writer Mary Barnes – who entered Laing's therapeutic community at Kingsley Hall in 1965, and underwent Laing's regression therapy – reinforced the merging of 'madness' and creativity. Barnes herself, and Joseph Berke, document her experience of 'schizophrenia' as 'a step on the way to truth'.[48] On discovering that she 'was quite unable to express any feelings in words', Barnes was encouraged to use visual art as a communicative tool.[49] Told to 'be as a child. Go mad.

[44] Aristotle, *Problems*, ed. by E. S. Forster (London: Aeterna Press, 2015), p. 127.
[45] By 'universal', I am referring to art's ability to be available to all who require it as a narrative model, and art's ability to be accessible to a social audience.
[46] Sander L. Gilman, *Difference and Pathology* (New York: Cornell University Press, 1985), p. 221.
[47] Laing, *Divided*, p. 89. As stated earlier, although I refer to Laing as a part of the anti-psychiatry movement, this is something of an oversimplification. Laing himself rejected the label, although it has been retrospectively applied to him and his work.
[48] Barnes, *Mary Barnes*, p. 17.
[49] Barnes, *Mary Barnes*, p. 51.

Regrow', Barnes's 'madness' was not oppressed or silenced in the walls of Kingsley Hall, but liberated.[50] She described how 'painting […] got me together, my body and soul. All my insides come out through my hands and my eyes and all the colour. It was free and moving, loving and creative'.[51] Rather than experiencing her 'madness' as something to be confined and controlled, Barnes's journey through (rather than *against*) her 'schizophrenia' resulted in freedom, fluidity and creativity.

Barnes's paintings, first put on public display in 1969 at the Camden Arts Centre, have now been exhibited all over the world, and have been hailed for their use of 'vivid colour [and] religious imagery'.[52] Since her death in 2001, recent exhibitions have led reviewers to conclude that 'Barnes is the best contemporary British artist not working today'.[53] However, Barnes's profile as an artist is inextricable from her identity as a 'schizophrenic': reviewer George Barber commented that 'because Barnes' life hangs so heavily over her art, one feels somewhat constricted as a viewer'.[54] Barnes is understood to be an artist *because* of her 'madness', and so her treatment at Kingsley Hall (and subsequent account) further ratifies the societal assumption that an unsound mind is also a creative one. Writer and art therapist David Maclagan argued that this merging of self/art is characteristic of the Outsider Art movement, as 'the story behind it [the art] is intimately involved in establishing its authenticity'.[55]

Although the 'mad' self may be inextricable from its projection (in this case, the artwork), there is a suggestion that art is still able to offer an accessible narrative, even to the 'other'. Tolstoy argued that 'the activity of art is based on the fact that man, as he receives

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[50] Barnes, *Mary Barnes*, p. 109.
[51] Barnes, *Mary Barnes*, p. 145.
[52] Obituary of Mary Barnes, *The Guardian*, 13 July 2001 <http://www.theguardian.com/news/2001/jul/13/guardianobituaries.books> [accessed 24 January 2015].
[53] George Barber, 'Mary Barnes', *Frieze Magazine*, issue 138, April 2011 <http://www.frieze.com/issue/review/mary-barnes/> [accessed 24 January 2015].
[54] Barber, 'Mary Barnes'.
[55] David Maclagan, *Outsider Art: From the Margins to the Marketplace* (London: Reaktion Books, 2009), p. 11.

through hearing or sight the expressions of another man's feelings, is capable of experiencing the same feelings as the man who expresses them'.[56] The activity of art is empathy.[57] If a viewer is able to reflect on, for example, not only Louis Wain's evident disconnection from orthodox perceptions of 'reality' in his later work, but also *experience* the emotions and immerse themselves in the microcosm of a new or unfamiliar 'reality', then Wain's narrative is socially received. If the viewer can be temporarily 'other' enough to experience Wain's 'madness', then Wain is no longer 'other'. The idea that art has this capacity to 'infect people', to allow them to align themselves with an experience of 'otherness', however briefly, inevitably blurs the distinction between 'us' and 'other', between 'madness' and 'sanity'.[58] If the viewer can momentarily experience 'madness' in order to empathise with the artist, then they do not fit into either side of these binary oppositions. If the artist's experience of 'madness' can be understood as a variant of 'sanity' rather than its antithesis, then these binary oppositions which have enforced silence can, potentially, be entirely deconstructed.[59]

Tolstoy contended that because of this ability to 'infect', visual art is a much more powerful tool than language: 'art, unlike the word, to which one need not listen, is so highly dangerous in its capacity for infecting people against their will'.[60] Dewey believed that 'each art speaks an idiom that conveys what cannot be said in another language'.[61] Art compensates for – or reacts to – the inadequacy of language by taking narratives into a realm almost entirely divorced from it. Stripped away from semantic politics which inevitably 'other' the narrator, 'mad' art instead projects a narrative which can be 'recognised as the mirror of a

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[56] Tolstoy, *What is Art?*, p. 38.
[57] Again, this is not exclusive to visual art: as demonstrated in chapter three, literature can also be used to provoke empathy from the reader. However, the immediacy of visual art – as detailed earlier – means that a piece of art needs to forge a connection with the viewer quickly in order for meaningful engagement to occur. If an audience experiences empathy when viewing art, they are emotionally invested, thus making immediate dismissal unlikely.
[58] Tolstoy, *What is Art?*, p. 41.
[59] In chapter five, I discuss how 'madness' can be reconstructed as a spectrum rather than the 'mad'/'sane' dichotomy which currently dominates societal (mis)understanding and (mis)representation.
[60] Tolstoy, *What is Art?*, p. 41.
[61] Dewey, *Art as Experience*, p. 110.

self'.[62] However, the human tendency to categorise using language prevents art from being an experience entirely detached from semantics. Labels used to disrupt the absence of language – such as 'Outsider Art' – are evidence of a wider social inability to surrender to a narrative model which transcends or rejects lexical classifications and hierarchies.

Conversations about the nature of art stress its universality. Academic and writer Hester Parr observed the 'potential role of the arts in minimizing difference – through helping to ensure communication […] and inclusion', highlighting the accessibility of art and its concomitant merits as a narrative model.[63] To an extent, visual art is above and beyond language (and its politics) and, as a medium which provokes recognition and empathy; it seems a well-suited platform for 'madness' narratives. However, assumptions of how art will be received can, indeed, be far removed from the practice.

Kraepelin declared that 'mad' art was characterised by a 'startling senselessness and tastelessness', devaluing and dismissing this narrative model.[64] Described as 'peculiar' and 'queer handiwork', 'mad' art was pathologised: it was a symptom rather than a narrative.[65] Perceived as merely a by-product of 'otherness', 'mad' art was dismissed and thus silenced by psychiatry, much like the verbal narratives I have previously explored. If society is informed that 'mad' art is nothing more than a symptom, a rejection of its perceived worth becomes a self-defence mechanism, an intuitive reflex. It will remain 'other', lest the viewer have empathy and be 'othered' in turn: 'madness' by proxy. This medicalisation of 'mad' art continues the traditional silencing of 'madness' narratives: deemed 'meaningless smears'[66], 'incomprehensible computations'[67], merely 'characteristic of the schizophrenic imagination',

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[62] Ingram, *Cultural Constructions*, p. 98.
[63] Hester Parr, 'Mental Health, the Arts and Belongings', *Transactions of The Institute of British Geographers*, 31 (June 2006), 150-66 (p. 150).
[64] Kraepelin, *Dementia Praecox*, p. 59.
[65] Kraepelin, *Dementia Praecox*, p. 55.
[66] Prinzhorn, *Art of Insanity* , p. 64.
[67] Prinzhorn, *Art of Insanity*, p. 51.

rather than discussed in human terms.[68] Despite the theory that art offers a universally accessible platform, is there really any space in this realm for a narrative declared 'incomprehensible' by psychiatric hegemony?

Despite arguing that the main activity of art was empathy, Tolstoy believed that that which is pathologically 'incomprehensible' (to the point of 'otherness', thus apparently being beyond mainstream 'comprehension') has no place in the sphere of mainstream art. The comparison of 'incomprehensible' art to 'some kind of food that is very good but people cannot eat it' overtly suggests that such art does not serve its perceived purpose (much like the food that cannot be eaten), and so has little value.[69] Paradoxically, Tolstoy expected art to be 'accessible and comprehensible to everyone'[70], despite the 'business of art consist[ing] precisely in making understandable and accessible which might be incomprehensible and inaccessible'.[71] There seem to be degrees of inaccessibility. Some 'incomprehensibility' results in 'successful' art (because of its ability to 'convey a new feeling'), while other 'inaccessible' art is disregarded (deemed to serve no purpose, much like the food that cannot be eaten).[72] So where is this arbitrary line drawn? Despite its premise of universal accessibility, it would appear that art's manifesto – that *everyone* has 'complete and unhindered communication' – remains more theory than practice.[73]

'Audacity and Inventiveness Beyond the Familiar': Outsider Art[74]

It has been suggested that a position of 'otherness' is a sort of prerequisite for the figure of the artist. Dewey believed that the nature of art demands 'some measure of "abstraction"

[68] Prinzhorn, *Art of Insanity*, p. 57.
[69] Tolstoy, *What is Art?*, p. 80.
[70] Tolstoy, *What is Art?*, p. 81.
[71] Ibid.
[72] Dewey, *Art as Experience*, p. 109.
[73] Ibid.
[74] Lucienne Peiry, *Art Brut: The Origins of Outsider Art*, trans. by James Frank (Paris: Flammarion, 2001), p. 12.

from physical existence', as this external perspective allows for a different – and thus innovative – view of the world.[75] The idea of the creative outsider is not far removed from the stereotype of the 'mad' artist: 'otherness' invariably offers a new perspective. Adolf Wölfli, for example, has been described as presenting an 'encyclopaedic view of the world' through his art, by virtue of his marginalised vantage point.[76] However, this does not necessarily mean that such art is accessible. Cultural historian Sander Gilman describes this positioning as the '*persona* of the outsider, which he [the artist] dons like a helmet to do battle with society'.[77] The idea that this must be a persona silences lived experiences of the outsider. If it is merely a performance of 'otherness', it is not 'otherness'. Only those included in society may engage with it, or 'battle' with it, even if this is done through a performance of marginalisation. For the truly marginalised, any form of social engagement – even a critique – is all but impossible.

The art world may feel that it is including the perspective of the outsider, but only if it is not *too* 'other'. In this limited criterion, there seems to be little space for the raw art exemplified by Barnes painting with excrement and August Klett impressing symbols on walls using fat. However, the Outsider Art movement offers the potential for such art to be accepted, as long as it simultaneously acknowledges its own 'otherness'.[78] Outsider Art has been described as a genre which 'encompasses individuals who belong to no movement or school, who are mainly self taught, have no knowledge of other art or artists and are adept at

[75] Dewey, *Art as Experience*, p. 98.
[76] Deborah Carter-Park, Paul Simpson-Housley and Anton de Man, 'To the "Infinite Spaces of Creation": The Interior Landscape of a Schizophrenic Artist', *Annals of the Association of American Geographers*, 2 (June, 1994), 192-209, (p. 195).
[77] Gilman, 'Madman as Artist', p. 588. Italics added for emphasis.
[78] Although the term 'Outsider Art' was not in general usage until 1972, Jean Dubuffet's title of 'Art Brut' (coined in 1945) had previously covered such work. Many consider Prinzhorn's publication to be a text which contributed to the genesis of the movement. Although this is problematic considering the nineteenth-century focus of my thesis, I am considering the *enduring* accessibility of these 'madness' narratives, and thus a retrospective consideration of such art as part of the Outsider Art/Art Brut movement is necessary in understanding the context of the art I address from a modern perspective. In addition, here and throughout my thesis I refer to the Outsider Art movement *as* a 'movement' for the sake of concision: in reality, it would be more apt to call it an anti-movement, in light of Maclagan's claims that Outsider Art is considered such due to its 'utter originality' and the 'isolation of its creator': both of which invalidate any attempts to apply a homogenising label to the unique 'otherness' of this art. See Maclagan, *Outsider Art*, p. 14.

exploring their own psyche'.[79] In this realm, art owes no debt to history or artistic traditions. A defining feature of Outsider Art is a subversion of traditional concepts of art: compare the culture of 'professional' Royal Academy artistry with the Outsider Artist who 'is unaware that he operates in the domain of artistic creation'.[80]

Of primary significance is the idea that artists in the movement 'are adept at exploring their own psyche'.[81] This is particularly important when understood in a psychiatric context. In this movement, a 'mad' artist can be the master of their own psyche. Although the artist must be the 'outsider' (and thus 'other') in order to gain this freedom, they are simultaneously an 'outsider' to hegemony. Psychiatry cannot 'other' them but, in order to be liberated from psychiatric classifications, they must first 'other' themselves by *becoming* the 'outsider' – and, of course, exposing the self to new labels, not least that of 'Outsider Artist'.

Outsider Art offers a platform for 'untrained artists […] who are not part of the mainstream tradition': it is a microcosm divorced from the canon which allows 'mad' art to sustain its own rhetoric.[82] However, it does not allow for a socially viable narrative. Imagine a viewer – fed on a diet of Royal Academy Realism – encountering a wall, exhibiting Barnes's representation of a pair of breasts, painted with her excrement. The viewer is unsettled, perhaps repulsed.

They declare: 'this is not Art!'

We reply: 'yes it is. It is *Outsider* Art'.

The viewer nods knowingly and is likely to dismiss the art.

By creating a niche for less orthodox art, Outsider Art offered the potential for a narrative without forcing the artist to pander to artistic traditions, or negotiate the politics of

[79] Outsider Art: Tate Britain Exhibition <http://www.tate.org.uk/whats-on/tate-britain/exhibition/outsider-art> [accessed 26 January 2015].
[80] Peiry *Art Brut*, p. 12.
[81] Outsider Art: Tate.
[82] *OED*, 'outsider' <http://www.oed.com/view/Entry/133984?redirectedFrom=outsider+art#eid32807369> [accessed 26 January 2015].

canonicity. However, the necessary acceptance of the 'outsider' position obstructs the third stage of the narrative process: delivery to a social audience. Although the individual may be empowered by the ability to 'other' themselves, rather than be marginalised by psychiatry (although this may have already happened), the narrative is still 'other', and thus is likely to be disregarded by a mainstream audience. Delivery to an audience is possible, as the genre of Outsider Art offers a medium suited to unconventional art, however – paradoxically – inclusion in this bracket requires an acceptance of 'otherness'. Any Outsider Art which merges with popular culture does so under a label which clearly demarcates an assumption of difference. Can a narrative which is introduced as 'other' ever be socially familiar? Can an experience demarcated as that of the 'outsider' be validated by the 'insiders'?

I have displayed how just a brief glimpse into the politics of producing, categorising, and viewing art can, indeed, deconstruct the idea that art is the only medium 'of complete and unhindered communication'.[83] I have established the impact that such politics could have on 'mad' art. I will now take this theory into the practical realm, by using it as a foundation to explore the (in)accessibility of 'madness' narratives by my chosen artists. Will this application reveal that art is a universal narrative platform, and therefore a suitable medium for the narration of 'madness'? Or will the reality undermine this hypothesis? Most importantly, what impact do these politics have on the accessibility of 'madness' narratives? If art is not available, what is?

'I Shall Change the Position of the Stars by an Act of Will': Hyacinth Freiherr von Wieser[84]

Little is known about Hyacinth Freiherr von Wieser: he remains as a *re*construction: his only enduring narrative exists in Prinzhorn's study of 'schizophrenic' art.[85] His experiences have

[83] Dewey, *Art as Experience*, p. 109.
[84] Prinzhorn, *Art of Insanity*, p. 124.

been employed by Prinzhorn as a psychiatric tool, and his art has been viewed merely as a symptom of 'madness', rather than as a bid for narrative power. However, by examining Prinzhorn's text in order to deconstruct psychiatric politics and access individual experience, I reread Wieser's 'madness' narrative. Through the lens of art theory, I explore the potential for Wieser's narrative to be accessed by a mainstream audience, and assess the credibility of visual art as a narrative model.

Born in 1883, Wieser was described as 'sensitive and idealistic' as a teenager.[86] His date of incarceration was not recorded, however, it allegedly followed a period in which he 'hallucinated more and more, talked nonsense, and suffered from hypochondria, a fear of being poisoned, and sudden excitements'.[87] Throughout the entirety of Prinzhorn's significantly brief account of Wieser's incarceration, there is a running theme of Wieser resisting medicalisation. He displays 'an urge to discover magic, supernatural relationships for all external events and especially for his own strange experiences'.[88] Justified as a quest for 'new and real knowledge', Wieser resists psychiatric 'authority' by trying to obtain *real* knowledge (thus exposing psychiatric knowledge as fake: a language *about* 'madness' and not *of* it).[89]

For answers, Wieser explored supernatural discourses rather than the scientific one which was being imposed on him. Predictably this rejection of hegemony is deemed 'absurd' and 'grotesque' by the psychiatric report.[90] However, it empowers Wieser. In the microcosm of the 'patient'/psychiatrist dynamic, Wieser has disregarded the power of the psychiatrist and, by association, rejected the role of 'patient'. The account records Wieser standing at the window of the asylum (and thus symbolically turning his back on the environment which

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[85] In order to view Wieser's account as a *human* narrative rather than a psychiatric one, I will refer to him as his real name rather than his pseudonym. I will also do the same with August Klett.
[86] Prinzhorn, *Art of Insanity*, p. 123.
[87] Ibid.
[88] Prinzhorn, *Art of Insanity*, p. 124.
[89] Ibid.
[90] Prinzhorn, *Art of Insanity*, p. 124.

attempts to control him): 'he stands for hours at an open window with a spoon in his hand and stares into the sky, saying, "I shall change the position of the stars by an act of will"'.[91] In an environment which serves to remove his authority, Wieser is resolute in his desire to be the master of his experiences. It is, of course, no coincidence that Wieser goes beyond the walls of the asylum to find answers – *real* knowledge. *This* is to be found in the sky, the stars, the trees in the garden: anywhere but in the mind and language of the psychiatrist.[92]

Before we engage with a specific example of Wieser's art, we must first unravel the art – Wieser's narrative – from a context which medicalises and dehumanises his experiences. Prinzhorn himself was both a psychiatrist and art historian, and had taken on the task of 'expanding an existing collection of art and artefacts crafted by the mentally ill, which was initially inaugurated by Kraepelin'.[93] This was not a project he started of his own volition because of his interest in art. Prinzhorn often did not have contact with the 'patients' he discussed, instead inviting colleagues to send accounts and artwork. Thus, the narratives we receive through Prinzhorn's work have been constructed and reconstructed through a dual psychiatric lens.

Further, in other publications, 'Prinzhorn used the term *bildnerei* ("image-making") as opposed to *kunst* ("art")'.[94] Through this distinction, he established a clear binary between art (and thus his academic background) and 'mad' art. 'Mad' art was therefore something 'other' than art: it was a symptom, and had little worth other than as a psychiatric tool. After featuring in Prinzhorn's study, much of the art was released to be used in a travelling Nazi exhibition on 'Degenerate Art' which opened in 1938, with the aim of further reinforcing 'the

[91] Ibid.
[92] Wieser's rejection of hegemonic discourse – in favour of championing personal experience and his own quest for knowledge – echoes the archetypal Romantic rejection of Enlightenment and celebration of the anthropocentric. The idea that knowledge can be found in the sky or the garden – as opposed to embedded in grand narratives of psychiatry, science, Industrialisation or Enlightenment – reflects an intense appreciation of the natural world, another defining feature of Romanticism.
[93] Prinzhorn, *Art of Insanity*, p. 5.
[94] Ibid.

"worthlessness" of the artistry of the mentally ill – which eventually culminated in the claim of the unworthiness of the mentally ill themselves'.[95] The various labels which impress themselves on this art immediately condemn it to a state of 'otherness'. The idea of degeneracy denotes 'one who has lost, or has become deficient in, the qualities considered proper to the race or kind', thus the label of 'Degenerate Art' suggests something lacking, something 'other' than human.[96] The title *The Art of Insanity* immediately evokes a sense of distance. It is not art but the art of 'insanity': it is a by-product of 'madness'. In the sub-title, we are introduced to 'Ten Schizophrenic Artists': they are 'schizophrenics' first, artists second. Their art is a result of their 'schizophrenia'.

An acknowledgement – and negotiation – of these paratexts is necessary for the viewer to access Wieser's narrative. The various labels which hover over Wieser's work ('image-making' rather than art; the art of 'insanity'; 'Degenerate Art') serve to undermine the value and accessibility of his art by presenting it as 'other' ('other' than art, or, indeed, degenerate – that is other than human). The presence of not one but two psychiatric paratexts (the account written by Wieser's psychiatrist, which was then reconstructed by Prinzhorn) enforces distance between the 'mad' voice and potential audience. As I have already established, context can have a dramatic impact on how the viewer interprets the work, and the dual psychiatric presence which frames Wieser's work is eager to convince the viewer of his 'otherness' before his art has even been presented.

Prinzhorn featured six examples of Wieser's work in *The Art of Insanity*, displaying them alongside a reconfigured account of Wieser's incarceration and the progression of his 'madness'. The images are fairly similar in both style and form, with the favoured medium

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[95] Thomas Schramme, 'The Quest to Understand the Afflicted Mind: Hans Prinzhorn and the Artistry of the Mentally Ill', in *Mental Health, Psychiatry and the Arts*, ed. by Victoria Tischler (Oxon: Radcliffe, 2010), p. 33-42 (p. 35).

[96] *OED*, 'degenerate' <http://www.oed.com/view/Entry/49054?rskey=ksPgUZ&result=1&isAdvanced=false#eid> [accessed 27 January 2015].

being merely a pencil and paper: Wieser's sketches are stark and bold, and often minimalist. The account explained that Wieser 'had already drawn and painted a little as an amateur' prior to his incarceration.[97] The psychiatric presence briefly mentioned that Wieser also created 'some watercolour landscapes […] with a surer perspective and lively colours'.[98] However, as the sketches allegedly represented Wieser attempting to 'reproduce his delusions on paper' under the instructions of his psychiatrist, they held more interest for Prinzhorn than the landscapes (presumably not 'other' enough to present a spectacle).[99]

Figure 1: Hyacinth Freiherr von Wieser, *Circle of Ideas of a Man, Projected on the Outside World*, pencil, 24 × 33cm.[100]

[97] Prinzhorn, *Art of Insanity*, p. 125.
[98] Ibid.
[99] Ibid.
[100] Image scanned from Prinzhorn, *Art of Insanity*, p. 125.

Before I offer an interpretation of *Circle of Ideas of a Man, Projected on the Outside World*, the context demands that we first acknowledge Prinzhorn's 'authority' by looking at the analysis which features alongside this image:

> In it we see a mighty head which looks as if made from a slab of stone breaking open at the top and transformed into a bouquet of small tableaus [*sic*], including a palace, a tournament, a lion, and women. A metal strip with nails seems to hold the skull together. Its even construction and the precision of many parts, notably the hand, betray the practised drawer. The head's disquieting effect is probably due to the calm objectivity with which Welz depicts the 'projected circle of ideas'.[101]

This initial description seems to stem from Prinzhorn's academic background as an art historian rather than his role as a psychiatrist. His focus on Wieser's superficial aesthetics – particularly the detail in the hand, which he believes 'betrays' practice and talent – suggests a focus on technical ability rather than symbolic interpretation. It is only later, when prompted by more abstract work, that Prinzhorn reflected: 'He [Wieser] is wrong in thinking that actual ideas can be represented'.[102] Prinzhorn deemed Wieser's ideas too 'other', and therefore they are unable to find physical representation through art. Arguing that, in his art, Wieser proves 'that his very idea contains the seed of absurdity', Prinzhorn depicted Wieser's narrative as a space in which even Wieser can recognise his own 'otherness'.[103]

Circle of Ideas of a Man, Projected on the Outside World can be seen to epitomise a struggle between the concrete (the geometric, the absolute) and the abstract (and thus unknowable). Wieser attempts to pin down his ideas, to present them in physical, concrete terms. The head of the figure opens up to reveal a series of images – the 'ideas of a man' – 'projected' into the external domain. However, the title itself is telling: it is *a* man, rather than the self, thus Wieser was able to distance himself from the figure in the sketch (and therefore protect the self, to an extent, from the gaze of psychiatry). These thoughts are projected onto

[101] Prinzhorn, *Art of Insanity*, p. 125.
[102] Prinzhorn, *Art of Insanity*, p. 127.
[103] Prinzhorn, *Art of Insanity*, p. 126.

the outside world, exposed. To return to my earlier discussion of the problems latent in accepting the role of 'outsider', Wieser suggested that it is the *outside* world which is 'other'. *Circle of Ideas of a Man, Projected on the Outside World* attempts to blur the distinctions between what is internal (ideas) and external (the outside world). This projection of a private, personal narrative into the external, psychiatric context is a powerful metaphor for the process of self-exposure latent in accepting the 'patient'/psychiatrist dynamic. However, the physical presentation of ideas suggests anything other than passivity.

The prominent idea is the oversized lion, vast enough to clamber over the roof of a building. Signifying strength and nobility, the image of the lion supports my earlier argument that Wieser was empowered by his independent quest for *real* knowledge. In a psychiatric environment which threatened to render Wieser helpless and silent, his narrative was constructed using images of *power*, from his desire to 'change the position of the stars by an act of will' to his inclusion of lion imagery.[104] Due to the size of the reproduction of the image (yet another contextual variable which Prinzhorn presumably dictated), it is difficult to pick out other details, despite the bold, understated nature of Wieser's sketch. This seems to be a manoeuvre to ensure that only Prinzhorn and Wieser's initial psychiatrist have interpretive agency.

As Wieser's work has been reconstructed and thoroughly medicalised through a dual psychiatric lens, his narrative can either be viewed as a symptom or as art. As I will demonstrate over the course of this chapter, it cannot be both, as the concept of the 'mad' artist is paradoxical. Could a theoretical approach work to ascertain the artistic value of Wieser's narrative? Dewey articulated a triadic relation which depicts the relationship that art has with mainstream society: 'the external object, the product of art, is the connecting link

[104] Prinzhorn, *Art of Insanity*, p. 124.

between artist and audience'.[105] Because of this relationship, Dewey argued that art 'cannot be private': it relies on social engagement to verify its status *as art*.[106] However, this relationship is somewhat complicated by the context of Wieser's work. The external object – the art – is reproduced in Prinzhorn's text, which encompasses both the image and Prinzhorn's analysis: to a mainstream audience, the two are inseparable. Further, the psychiatric context confuses the notion of 'audience'. Wieser produced his art in an asylum, prompted by his psychiatrist to try to reproduce his delusions. In this microcosm, Wieser's psychiatrist is the audience. The psychiatrist then reconstructed Wieser's narrative to give to Prinzhorn, who was, in that moment, the audience.[107] Prinzhorn then crafted his own external object – his text – around Wieser's external object (his art), and delivered it to a social audience. In the remit of a standard triadic relation, only the external object (the art) simultaneously stands in-between and bridges the gap between artist and audience. However, in this context, there is now an external object, a text, and two psychiatrists standing in-between artist and audience, interpreting, reframing and, ultimately, distorting Wieser's narrative. As this psychiatric context confuses the orthodox relationship between artist and audience, it may serve to declare Wieser's narrative as something 'other' than art.

Philosopher Thomas E. Wartenberg, when discussing the various criteria involved in demarcating art from *non*-art, observed that 'those who have had training in the appreciation of a given art form […] are more qualified to determine what are and are not instances of it'.[108] With this in mind, Prinzhorn's academic background as an art historian does afford him interpretative power, allowing him to judge if Wieser's work is, indeed, art. Wieser's narrative is introduced as art, insofar as the text is called *The Art of the Insane*. However, as

[105] Dewey, *Art as Experience*, p. 111.
[106] Dewey, *Art as Experience*, p. 112.
[107] There is potential to argue that the artist is simultaneously the creator and original audience for their work – particularly in the context of art which serves a therapeutic purpose. However, I am looking at this from the perspective of narrative theory, which, in accordance with the three stage process detailed in chapter one, necessitates acknowledgement from a social audience for a narrative to succeed.
[108] Thomas E. Wartenberg, *The Nature of Art: An Anthology* (Boston: Wadsworth, 2011), p. 5

my previous discussion has proved, it is a context which draws attention to the 'otherness' of the art: Prinzhorn carefully employed semantics to suggest it was a process of 'image-making' rather than 'art'.

Wartenberg believed that 'art objects are created by artists who are consciously trying to make art'.[109] To what extent are the reader and viewer encouraged to consider Wieser as an artist? The context of Wieser's narrative ensures that his identity as a 'schizophrenic' is paramount: any potential artistic credibility is incidental. Prinzhorn accepted that Wieser was a 'practised drawer', but did not call him an artist.[110] Because of psychiatric framing, these questions of context and artistic credibility have already been answered for the viewer. Prinzhorn, as psychiatric 'authority' – with the added credibility of being an art historian – has constructed and imposed his interpretation: the reader/viewer is unlikely to be inclined to challenge this dual expertise.

Based on these theoretical approaches, it would appear that Wieser's narrative is not art in a canonical, and thus societal, sense. It is difficult, if not impossible, for mainstream society to access Wieser's work as art rather than a symptom. The psychiatric belief that 'attending or listening to the voice of the mad is pointless since, by the virtue of their unreason, their views are worthless' dominates the triadic relation.[111] Although Wieser displayed reason (through his geometric art and quest for *real* knowledge), the psychiatric context must portray it is as 'absurd' rather than credible in order to devalue Wieser's reason (and thus portray him as a 'patient').[112]

However, the perceived and expected nature of what constituted art was changing in the nineteenth century, away from Realism towards the anthropocentric. The idea that art

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[109] Wartenberg, *Nature of Art*, p. 2. Interestingly, by this criterion, Outsider Art would be considered non-art in light of Peiry's claim that the Outsider Artist 'is unaware that he operates in the domain of artistic creation'. Peiry *Art Brut*, p. 12.
[110] Prinzhorn, *Art of Insanity*, p. 125.
[111] Ingram, *Cultural Constructions*, p. 25.
[112] Prinzhorn, *Art of Insanity*, p. 126.

could reflect and explore 'uncovered deep determinants of human behaviour' changed the relationship between art and audience: the audience, instead of anticipating a flawlessly imitated landscape or a true-to-life portrait, approached art expecting to exhibit interpretive agency.[113] With this in mind, *Circle of Ideas of a Man, Projected on the Outside World* may offer the potential for mainstream engagement, were it to be divorced from its psychiatric context. The fact that Wieser represented a man, rather than the self, is significant: it could be any man, it could even be the viewer. Thus, Wieser did not present his narrative as a product of his 'madness': it is, instead, a commentary on the human condition. It is a point of similarity, an image which *unifies*, rather than a narrative which exposes Wieser's alleged difference. However, in a context which resolutely reinforces Wieser's 'otherness', this bid for narrative power has been supressed. The psychiatric framing has already claimed the narrative as a tool, a symptom, the art has already been deconstructed and scrutinised by the assumed 'authority'.

'Meaningless Smears Approach Serious Art': August Klett[114]

In order to establish the impact of context further, it is necessary to explore the work of August Klett (granted the derogatory pseudonym 'Klotz' by Prinzhorn: 'Klotz' being 'a pejorative term for an idiot').[115] In much the same manner as Wieser, Klett's art was featured by Prinzhorn as proof of 'some marked deviation from conventional or normal ways of acting, or thinking, or feeling [...] to make it appear that there must be something lacking in

[113] McKay, 'Art, Madness', p. 418. As art became increasingly abstract – as exhibited by the rise of Post-Impressionism and Modernism – its *meaning* destabilised further. In the context of Realism, *re*presentation is a fundamental aim: as demonstrated by the reviews of the 1847 Royal Academy exhibition, artistic credibility is judged by how well imitative art recreates the subject matter. However, abstract art cannot be judged by such criteria, and so artistic value and meaning become even more fluid, often being dependant on the interpretation of the viewer who, in the absence of clearly defined subject matter, has relative free rein to interpret and find meaning in the art.

[114] Prinzhorn, *Art of Insanity*, p. 64.

[115] Gilman, 'Madman as Artist', p. 588.'Klotz' also echoes the Yiddish term 'klutz', referring to someone clumsy.

the constitutional makeup of the individual'.[116] However, Klett's identity as an artist/'schizophrenic' (the two are inseparable because of his psychiatric context) has endured beyond hegemonic discourse which sought to control it. Reclaimed as one of the artists fundamental to the genesis of Outsider Art, Klett's work adorns the covers and the content of a handful of critical and historical accounts of the movement.[117] It would appear that Klett's 'schizophrenic' diagnosis did not jeopardise his identity as an artist, despite the psychiatric framing, or indeed, *because* of this psychiatric framing: Outsider Art championed those who were socially or psychologically marginalised. Klett's status as a 'patient' verifies his position as an 'outsider'.

Born in 1864, Klett led a fairly unremarkable life (or, at least, a life removed from the psychiatric gaze) until 1903. Following a bout of influenza, Klett 'fell into depression, feared sin […] and was afraid that he might die. Hallucinations appeared and caused him to become greatly excited'.[118] After an instance of self-mutilation, Klett was incarcerated. Prinzhorn remarked that 'Klotz had been drawing earlier than most of the patients on whom we report in this book'.[119] Klett's desire to create – and narrate – led to him rubbing figures 'into the wallpaper with fat […] which could not be wiped off'.[120] This raw, enduring form of artistry reveals a compulsion to create, regardless of what materials were to hand, reflecting the 'urgency, an internal *necessity*' which drove Adolf Wölfli's art, and would later be echoed in the work of Barnes.[121]

In 1905, Klett created a 'colour alphabet', in which each letter of the alphabet is assigned a colour: for example, '2b = Bronze colour metal'; '6f = fire flame red'; and '9i =

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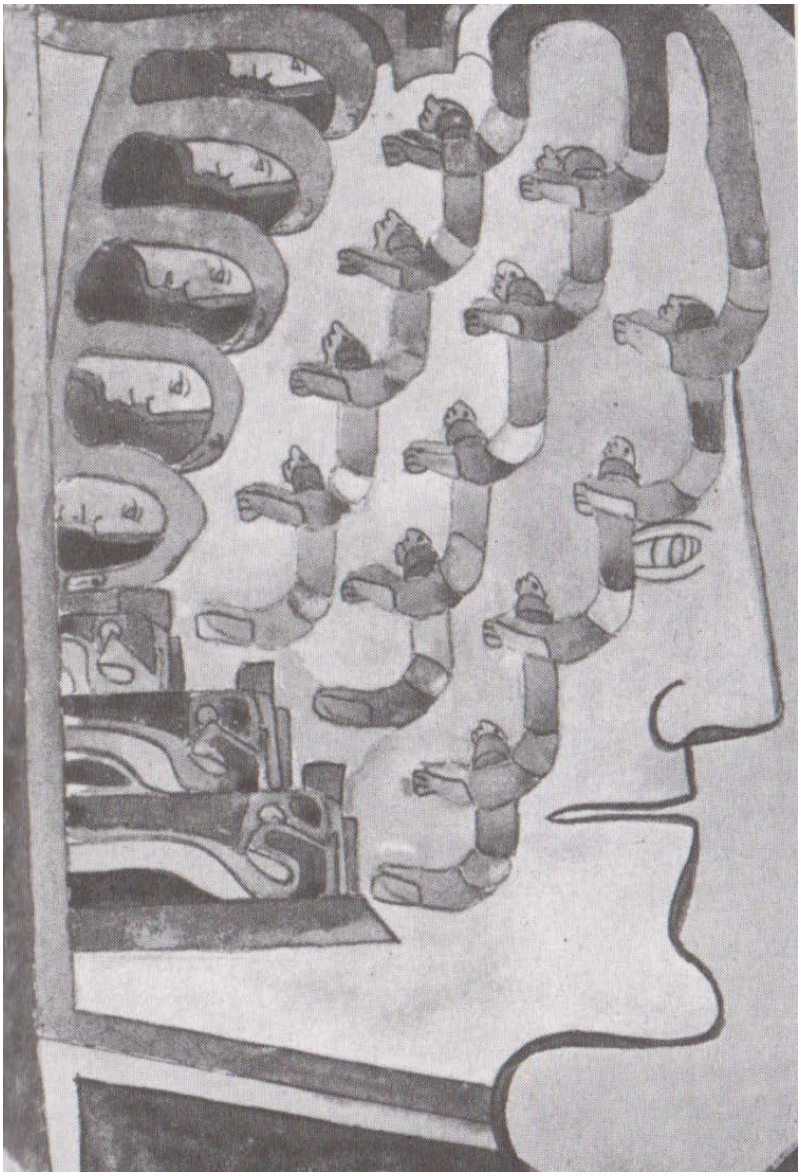
[116] Faris, 'Cultural Isolation', p. 156.
[117] See Jean Louis Ferrier, *Outsider Art* (Paris: Terrail, 1998) and Roger Cardinal, *Outsider Art* (London: Studio Vista, 1972).
[118] Prinzhorn, *Art of Insanity*, p. 50.
[119] Ibid.
[120] Prinzhorn, *Art of Insanity*, p. 51.
[121] Walter Morgenthaler, *Madness and Art: The Life and Works of Adolf Wölfli*, trans. by Aaron H. Esman (Nebraska: University of Nebraska Press, 1992), p. 22. Italics added for emphasis.

sky blue forget-me-not'.[122] Although art theory described art as 'a language [or] many languages', Klett took this approach to a literal level.[123] Discarding the current alphabet (and thus rejecting the grand narrative of language), Klett created his own: a language of colour rather than vocabulary. Reminiscent of 'schizophrenese', Klett invented a semantic system, a new space in which the self can be reconstructed and narrated. These detailed 'pairings of letters and colours'[124] are suggestive of grapheme-colour synaesthesia, in which 'a letter or number triggers an experience of colour'.[125] Predictably – and ironically, considering his Kraepelinian psychiatric background – Prinzhorn viewed this as a symptom, a 'compulsion to systematize'.[126] However, much like Wieser's desire for *real* knowledge, this is a significant rejection of hegemonic discourse, a refusal to rely on language (a psychiatric tool) to delimit an experience of 'madness'. The psychiatric account observed that Klett 'does not feel at all inhibited by conventional knowledge, but proceeds entirely playfully and arbitrarily'.[127] Klett's experience transcended conventional knowledge, as 'the expression of madness exceeds what is possible to talk about using conventional […] discourse'.[128] Thus, Klett was compelled to create a *new* discourse in order to accommodate it. The psychiatric presence dismissed Klett's system as 'playful', something of little consequence, ignoring or refusing to acknowledge the revolutionary significance of such self-sufficiency.

[122] The full colour alphabet can be found in Prinzhorn, *Art of Insanity*, p. 52. We must, of course, keep in mind that Klett's alphabet and his transcript which I explore shortly have been translated (both literally – from German to English – and by the dual psychiatric presence).
[123] Dewey, *Art as Experience*, p. 110.
[124] Johannes Deutsch, 'Synaesthesia and Synergy in Art', in *Sensory Perception: Mind and Matter*, ed. by Friedrich G. Barth, Patrizia Giampieri-Deutsch and Hans-Dieter Klein (New York: Springer Wien, 2012), pp. 215-30 (p. 231).
[125] Berit Brogaard, 'Seeing as a Non-Experiential Mental State: The Case from Synaesthesia and Visual Imagery', in *Consciousness Inside and Out: Phenomenology, Neuroscience, and the Nature of Experience*, ed. by Richard Brown (London: Springer, 2014), pp. 377-94 (p. 392).
[126] Prinzhorn, *Art of Insanity*, p. 52.
[127] Prinzhorn, *Art of Insanity*, p. 54.
[128] Cross, *Mediating Madness*, p. 29.

Figure 2: August Klett, *Worm Holes Etc.*, watercolour, 25 × 33cm.[129]



Both Wieser and Klett reached beyond the psychiatric realm to understand their experiences, and thus their art offers a potential counter-narrative: a discourse *of* 'madness' and not *about* it. However, psychiatric framing allows for this threat to be supressed and defused. Klett's art was accompanied by verbal descriptions, which Prinzhorn dismissed as 'nonsense', which 'at least is amusing'.[130] Figure 2 is a piece produced by Klett in 1919, using watercolours.[131] Klett also produced the following inscription:

[129] Image scanned from Prinzhorn, *Art of Insanity*, p. 61.
[130] Prinzhorn, *Art of Insanity*, p. 56.
[131] Klett's work has been reproduced in *The Art of Insanity* in black and white, therefore making the colour redundant. This clearly shows the distortion of Klett's narrative – it has been thoroughly 'plundered, organised

> Worm holes (bath faces) worm paths (pianomusicstickteeth) worm strings (spitbathlife of the archlyregallery-tin-timeler-reflections: ad mothersugarmoon in the sevensaltnosewater. The seeingtongue is in the headtonsils of the lowerbodyhoden in the changetwitchfiver of the nosetip ad seesim-calender 1905 Jordon ad Biblia = torso = yes = donkey bridge = heytraject = stealingholesticker = chestnutwoodghostants = copper red = glassmilk = lakmus = lackeys = calcium: lamb-ear on the stone eye on the heart = sod under the Brunsteiter = cancer: godrock = son = saltsule = Hymenghost = trinity ammonia salmia spiritus veris (antghostwormturn) porcupinefish = caviarstaterholes = im = stomachnoseearmouth 'eye' = polish = polizze = thumbs = ladiessleepsilvertrade = ad M. 500000Y ad Eschrich Zimmermann 27 March 1919 fingerhackelthumbsladieskidneys = Miss Schwarz (30) Y 'Look at this and give support' lowerfaced – feeler – strontium – salad Dr.[132]

Although this text is a translation, it is necessary to acknowledge this description as part of Klett's art: his narrative, much like the work of English poet and painter William Blake, lies in the marriage of image and inscription. Reminiscent of Anna O, who attempted to construct her narrative 'laboriously out of four or five languages', Klett juggled and merged languages (both semantics and the language of art/colour) in order to articulate his experiences.[133]

Klett's reference to 'the seeingtongue' could be a reference to his intense creativity and synaesthesia ('a condition in which the senses mix together so that sensations we normally consider separate start to intermingle').[134] The dates featured ('1905' and '1919') correspond to Klett moving to the asylum in which he currently was, and the date of the painting, respectively. The final two words – 'salad Dr' – suggest a knowingness on Klett's part, an acknowledgement of the idea that such free association will be pathologised, declared 'word salad'. By nodding to this psychiatric hypothesis, Klett was able to play up to it, pre-empting the dismissal of his work. He deflected the notion of 'incomprehensibility' from the self onto his psychiatrist, the 'salad Dr'. However, even with only the brief information given

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and published'. Klett, as 'mad' narrator, had no agency over the production and reproduction of his art. A colour reproduction can be found at Aica Hellas, 'Works from the Prinzhorn Collection' <http://www.aica-hellas.org/en/topic71/works-from-the-prinzhorn-collection/f7_5_2_1> [accessed 16 June 2016]. I have included the version reproduced by Prinzhorn to expose this additional dynamic of misrepresentation.

[132] Prinzhorn, *Art of Insanity*, p. 61.

[133] Freud, *Hysteria*, p. 77.

[134] Smitha Mundasad, 'Word-Taste Synaesthesia: Tasting Names, Places and Anne Boleyn' <http://www.bbc.co.uk/news/health-21060207> [accessed 29 January 2015].

by Prinzhorn, it is possible to draw strong correlations between this 'nonsense' and Klett's situation, thus exposing Klett's inscription as something more than merely 'word salad'.[135]

Prinzhorn offered the following analysis of Klett's piece: 'we can still recognize his earlier playfulness in the arches, which consist of a combination of worms, fingers with nails, and the heads of caterpillars, while at the same time representing the hair'.[136] Reflecting on the 'suspended ambiguity of schizophrenic thought patterns' which 'fascinate' the viewer, Prinzhorn introduced Klett's art as a form of spectacle: a portal through which the viewer can witness the chaos of a 'schizophrenic' mind.[137] In a similar fashion to Wieser, Klett's art represents the construction of self, a reflection on what makes the mind. Despite this being a significant bid to configure the mind in physical (and thus controllable) terms (rather than abstract, which is the realm of psychiatry), Prinzhorn dismissed his work as 'an endless, aimless, somehow enjoyable game of interpreting forms'.[138] The inscriptions for the art make Klett vulnerable to psychiatric scrutiny, as he presented his narrative in lexical terms, thus evoking the politics and problems latent in the employment of such a narrative form. Prinzhorn manipulates the reaction of the viewer, commenting that '*we* observe […] the progressive dissolution of his personality as reflected in his written explanations of the pictures'.[139]

Klett has been constrained by the same insular context as Wieser: the psychiatric presence ensures that the triadic relation is disrupted, thus distorting the relationship between artist and audience. Further, due to being introduced as a 'schizophrenic' first and an 'image-maker' second, Klett and his work would fail to meet Wartenberg's criterion that 'art objects are created by artists'.[140] However, why is it that Wieser's work only exists in Prinzhorn's

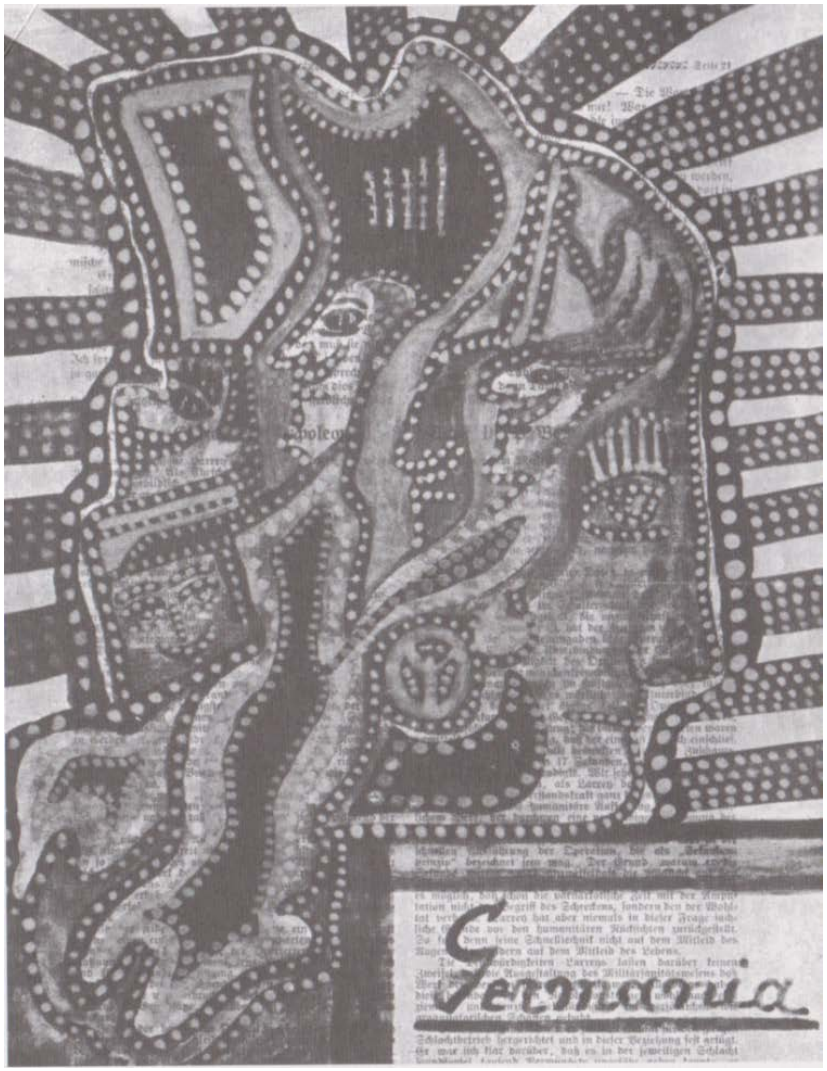
[135] Prinzhorn, *Art of Insanity*, p. 56.
[136] Prinzhorn, *Art of Insanity*, p. 61.
[137] Prinzhorn, *Art of Insanity*, pp. 63-64.
[138] Prinzhorn, *Art of Insanity*, p. 64.
[139] Ibid. Italics added for emphasis.
[140] Wartenberg, *Nature of Art*, p. 2.

text, and Klett's work has survived *beyond* (although never truly divorced from) this psychiatric context? If anything, the chronology of both artists should have resulted in a subversion of this social reception: the fact that Wieser (born 1883; incarcerated approximately 1908) produced his art *later* than Klett would, in theory, make him more likely to be championed by developing genres such as Post-Impressionism and Symbolism which celebrated originality over Realism. Despite this, Klett (born 1864; incarcerated 1903) found a niche in the ever-changing art world, whereas Wieser's work failed to reach a social audience outside of the boundaries of Prinzhorn's analysis. Was the success of one artist over another merely incidental? If so, how can contingent circumstances have such a dramatic impact on the social viability of one narrative over another?

Klett's work does make a more prominent appearance in *The Art of Insanity*, with eleven pieces featured, as opposed to the six examples of Wieser's work. Prinzhorn, as an art historian, did seem to favour watercolours: when faced with Klett's *Germania*, for example, Prinzhorn temporarily lost his psychiatric detachment. The painting is described, however briefly, in affective rather than medicalised terms: '[it] has a strong emotional impact in spite of strange formal inconsistences. Its colours alone make it a symphony of light green and light violet, and it emanates a mild and very subtle magic'.[141]

[141] Prinzhorn, *Art of Insanity*, p. 63.

Figure 3: August Klett, *Germania*, watercolour, 23 × 29cm.[142]



Was it simply a matter of form which caused Prinzhorn to overlook 'formal inconsistencies' due to a pervasive sense of 'subtle magic', and thus drop his psychiatric scrutiny in favour of the gaze of an art-lover? If we are to assume that it is merely Prinzhorn's taste which has led to Klett's work existing beyond the psychiatric context, there has been another significant omission. Wieser did produce watercolours, which were praised by Prinzhorn (described as 'more interesting, with a surer perspective and lively colours') but these did not feature in the text.[143] Although we have two 'schizophrenic' artists, represented

[142] Image scanned from Prinzhorn, *Art of Insanity*, p. 63.
[143] Prinzhorn, *Art of Insanity*, p. 125.

in the same context, using the same materials, one narrative has been heard (albeit in a limited social microcosm, as 'Outsider Art') while the other remains silent.

Prinzhorn's emotional connection with Klett's work is striking, and his analysis ends with the reflection that, occasionally, Klett's 'schizophrenic' identity fractures slightly to reveal his potential as an artist: 'a few pictures from among numerous, meaningless smears approach serious art'.[144] It is *not* serious art, Prinzhorn informed his readers, but it is approaching this status. Perhaps Prinzhorn's implication that Klett has the potential to be an artist, rather than just an 'image-maker' has resulted in the wider dissemination of his narrative. Prinzhorn's dual identity as art historian/psychiatrist gave him magnified 'authority': he could identify both 'madness' *and* art. In the case of Klett, Prinzhorn finds both: the fact that he acknowledged Klett's ability to be an artist and a 'schizophrenic' (rather than the art being solely viewed as a symptom of 'madness') could go some way to explaining Klett's relative success.[145]

Was it merely Prinzhorn's preferences which allowed one narrative to be successful and another to be silenced? It seems tremendously problematic that something as trivial and changeable as taste can ultimately determine the viability of a 'madness' narrative. The artist 'can never escape the thought of a potential audience' because such an audience will dictate the perceived worth of the narrative.[146] In light of this, using art as a platform for a vitally important 'madness' narrative seems far too unpredictable. Although the narrative is able to escape the politics of language, it now depends on the changeable tides of fashion and taste to determine its accessibility and, ultimately, judge its worth.

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[144] Prinzhorn, *Art of Insanity*, p. 64.
[145] Klett's relative 'success' here is judged by his inclusion in publications such as Ferrier, *Outsider Art*, and Cardinal, *Outsider Art*.
[146] Dewey, *Art as Experience*, p. 282.

‘I am Not Among the Tame. And Yet No Wild Animal’: Adolf Wölfli[147]

As a point of comparison with both Wieser and Klett, the work of Adolf Wölfli has, on the surface, liberated itself from the asylum and created its own space in art galleries (albeit under the problematic label, again, of Outsider Art). Although Wölfli’s life and incarceration coincided with those of both Wieser and Klett, the reputation of his art has surpassed both, and he is generally regarded to be a fundamental part of the foundation of Art Brut, which later became the Outsider Art movement.[148] Championed by psychiatrist Walter Morgenthaler, who later supported Wölfli by providing him with materials and ultimately writing his biography, Wölfli’s work was identified as *art* rather than as mere ‘image-making’. ‘Departing from the psychiatric practise of using a pseudonym, Dr. Morgenthaler wanted to signal that for him the artist matters as much to him as the insane patient’, thus Wölfli’s reputation as an artist (albeit an Outsider Artist) seemed to precede his ‘schizophrenic’ identity.[149] Where is this arbitrary line between the ‘madness’ narratives which appear to succeed and those which fail? By which criteria is Wölfli’s art publicised and Wieser’s lost to history?

Wölfli’s contact with psychiatry started in 1895, at the age of 31. Following ‘an attempted sexual assault on a three-and-a-half year old girl’, Wölfli was sent for psychiatric observation and was diagnosed as ‘schizophrenic’.[150] Wölfli would remain in the Swiss Waldau Asylum until his death in 1930, thus spending the majority of his life in a psychiatric environment which forced him into the role and identity of ‘patient’. In 1899, he started to draw in an attempt to ‘compile an autobiographical account of the chaos that confronted him in his old and his new worlds’.[151] During his incarceration, Wölfli produced extensive

[147] Adolf Wölfli, *From the Cradle to the Grave*, in Terezie Zemánková, *Wölfli: Creator of the Universe* (Bern: Arbor, 2012), p. 97.
[148] See Peiry *Art Brut*, pp. 52-53.
[149] Peiry, *Art Brut*, p. 22.
[150] Carter-Park, ‘Infinite Spaces’, p. 194.
[151] Carter-Park, ‘Infinite Spaces’, p. 195.

volumes of this 'autobiographical account', the progress of which has been described by Maclagan: '[it] starts off fairly close to the actual events, but soon takes off, first into imaginary globetrotting and then into a cosmic drama in which he is transformed into St Adolf II'.[152] This movement away from 'reality' displays a 'progressive escape of reality towards delusion' which allegedly characterises the development of the 'schizophrenic' condition.[153] However, despite this obvious (and increasing) departure from 'conventional or normal ways of acting, or thinking, or feeling', there have been exhibitions and museums that showcase Wölfli's work.[154] How does Wölfli's 'otherness' differ from the 'otherness' which proved an insurmountable barrier to the reception of Wieser's work?

Critical and psychiatric accounts of Wölfli's art echo the quest for 'evidence for the existence of a fundamental creative impulse' which characterised the genesis of the Outsider Art movement.[155] Throughout Morgenthaler's account of Wölfli's life and work, he observed that 'his method of work conveys the impression of an urgency, an internal *necessity* […] he doesn't usually give the impression of deriving particular pleasure from his work, but of fulfilling a painful duty'.[156] Reminiscent of Klett using fat to create patterns on the wallpaper, or of Barnes using her excrement to construct images, there is something urgent about the sort of creation which exists in the bracket of Outsider Art.[157] Wölfli was fortunate insofar as his relationship with Morgenthaler ensured he was never short of materials: he always had the resources to hand to create, and thus never had to resort to a *literally* raw or rough form of art. On the surface, there appear to be numerous similarities between Wölfli's circumstances and those of Klett and Wieser: all were reportedly 'schizophrenic' and incarcerated, their

[152] Maclagan, *Outsider Art*, p. 81.
[153] Silvia Helena Cardoso, 'Cats Painted in the Progression of Psychosis of a Schizophrenic Artist', *The Electronic Magazine on Neuroscience* <http://www.cerebromente.org.br/gallery/gall_leonardo/fig1-a.htm> [accessed 18 November 2010].
[154] Faris, 'Cultural Isolation', p. 156.
[155] Maclagan, *Outsider Art*, p. 8.
[156] Morgenthaler, *Madness and Art*, p. 22. Italics added for emphasis.
[157] The etymology of 'Art Brut' signifies something raw or rough. Under this title, the movement seemed well-suited to accommodate the work of Barnes and Klett, in addition to Karl Brendel's sculptures constructed using chewed bread.

lifespans overlap (Klett and Wölfli, in particular: both were born in 1864, and they died just two years apart) and their work was reproduced in a psychiatric context (Klett and Wieser by Prinzhorn, Wölfli by Morgenthaler). However, the perceived social accessibility of their work varies drastically, with Wieser all but a spectre in the art world, and Wölfli being hailed by scholar Elka Spoerri as 'one of the greatest artists of the 20th century'.[158]

There is a diversity of form: Wieser and Klett gravitated towards watercolour, whereas Wölfli's favoured materials seemed to be coloured pencils and/or crayons. Morgenthaler suggested that this preference was merely a matter of resources, as 'he draws as long as he has colored pencils, and then works on his biography, writes poems, and composes music when he has only plain lead pencils'.[159] Wölfli's rate of production was so intense that Morgenthaler reported that a box of coloured pencils would last 'two or three weeks at most', suggesting an insatiable desire to create and, ultimately, narrate.[160] However, Wölfli also merged forms and languages (using both semantics and the language of art): his work 'combine[s] verbal, ornamental, musical and pictographic ingredients in highly organised compositions'.[161]

[158] Obituary of Elka Spoerri, *The New York Times*, June 3 2003 <http://www.nytimes.com/2002/06/03/arts/elka-spoerri-77-who-decoded-works-of-noted-outsider-artist.html> [accessed 1 February 2015].
[159] Morgenthaler, *Madness and Art*, p. 21.
[160] Ibid.
[161] Morgenthaler, *Madness and Art*, p. 19.

Figure 4: Adolf Wölfli, *The Ballroom of Saint Adolf*, 1916, coloured pencil, 62.5 × 48cm.[162]

Amalgamating the verbal, the symbolic and the ornamental (particularly in the border detail) to construct a layered image, we are presented with the world of Wölfli's other self – the ballroom of Saint Adolf II.[163] The artistic embodiment of Wölfli's departure from 'reality'

[162] Image scanned from Peiry, *Art Brut*, p. 21.

[163] Wölfli's merging of languages goes beyond the visual. Michael Hall argued that the seemingly 'delirious semantic content' of Wölfli's art is 'rooted in the syntax and vocabulary of the Bernese dialect'. Wölfli also constructed his narrative using English, and other foreign words he knew from his access to 'illustrated

has been considered 'delusional mythology'.[164] Wölfli's self-created environment has been assumed to represent a 'schizophrenic inner world [which] replaces external reality', thus his art is proof of his 'otherness', something fundamental to Wölfli's 'madness'.[165] However, even if we were to assume that Wölfli's inner world had entirely replaced the external, this does not have to denote a status of 'otherness'.[166] Echoing Wieser's desire for 'real' knowledge and Klett's construction of his own alphabet, Wölfli created a space divorced from psychiatry: it is a bid for authority, a rejection of hegemony. In this self-created and self-governed realm, Wölfli was formidable, a saint, 'the companion and protégé of God-the-All-Powerful'.[167] His art empowered him in the same psychiatric environment which sought to render him a submissive 'patient'.

Throughout the volumes of his autobiography, Wölfli displayed an awareness of a potential audience, finally addressing his reader directly in the eleventh volume:

> To be sure, the entire verbatim text in this little book has the thought, attitude and character of a madman […] At bottom, it is however, fundamentally and throughout, a genuine and true edition and narrative. Thus, I herewith hope that the kind reader will appreciate my piece of entertainment staged in the cell of the mental asylum.[168]

Wölfli invited his 'kind reader' to look beyond the label of his 'madness' and instead receive his 'genuine' narrative. However, this bid for authenticity is distorted by the terms 'entertainment' and 'staged' which denote a performance, much like Klett referring to the psychiatric phrase 'word salad' in his inscription to Figure 2. There is a playful suggestion that Wölfli knew his art would be read as a symptom, and thus he was protecting his narrative

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calendars, journals, and magazines [and] other French- and English-language publications'. See Michael D. Hall, *The Artist Outsider: Creativity and the Boundaries of Culture* (Michigan: Smithsonian Institution Press, 1994), p. 32 and Carter-Park, 'Infinite Spaces', p. 196.

[164] Carter-Park, 'Infinite Spaces', p. 195.

[165] Ibid.

[166] The human capacity to imagine suggests an ability to manage numerous 'worlds' or 'realities'. We do not suggest that authors who explore other worlds (such as Carroll) do so because they have abandoned their own. They are able to distinguish between the two, as are their readers. Similarly, one is able to identify what is a dream and what is 'reality': one may experience both, but it does not imply a break from 'reality'. The idea that Wölfli was unable to recognise the external world (even if he had an alternative experience of it) because of his ability to create other worlds seems, at best, a harmful oversimplification.

[167] Morgenthaler, *Madness and Art*, p. *xiv*.

[168] Adolf Wölfli, *Geographic and Algebraic Books*, vol. XI, in Carter-Park, 'Infinite Spaces', p. 196.

from being 'othered' by psychiatry by presenting it as a sort of fictional construct: a creation of the self, but not *the* self. Perhaps the necessity for this protective manoeuvre *is* the 'genuine' narrative to which Wölfli referred. The very fact that it must be hidden in numerous layers and transmitted through a performance draws attention to the difficulties of articulating an authentic, personal narrative in a psychiatric context.

Art historian Lucienne Peiry argued that, in the Outsider Art movement, 'the artist is unaware that he operates in the domain of artistic creation', and yet this seems to contradict the knowing playfulness and experimentation which characterise Wölfli's work.[169] Wölfli seemed entirely immersed in the domain of artistic creation – regardless of whether this preoccupation is deemed to signify a total break from 'reality' or simply a manoeuvre to protect the self from a hostile psychiatric environment by creating a new space. However, that is not to say that Wölfli failed to acknowledge his 'otherness' in favour of his artistic persona. As with the extract from *Geographic and Algebraic Books* in which Wölfli explicitly referred to himself as a 'madman', his art also reflected on his psychiatric environment, thus embracing his position of social marginalisation. The 'mad' self is not divorced from the artistic self: Wölfli did not even attempt to separate the two.

Mental Asylum Band-Copse is perhaps the most overt example of Wölfli directly addressing his psychiatric context. It 'symbolizes his sense of the asylum's institutional embrace; it is one of his most grandiose and fearsome works of art'.[170] It displays an acknowledgement of Wölfli's external environment, contradicting claims that his art signified a total rejection of 'reality'. Standing in contrast to the vibrant colours and gentle curves which characterise Wölfli's inner world (*The Ballroom of Saint Adolf*) in Figure 4, the rigid structure-in-structure of his outer world (*Mental Asylum Band-Copse*) suggests claustrophobia and restriction.

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[169] Peiry, *Art Brut*, p. 12.
[170] Carter-Park, 'Infinite Spaces', p. 197.

Figure 5: Adolf Wölfli, *Mental Asylum Band-Copse*, 1910, pencil and coloured pencil, 99.7 × 72.1cm.[171]

Described as ‘naïve and child-like. It ignores perspective, lacks horizons, and uses the child-like device of looking from above’, this piece has been interpreted as symbolic of Wölfli’s ‘otherness’.[172] This infantilisation of the ‘mad’ individual conforms to wider ‘cultural

[171] Image scanned from Zemánková, *Wölfli*: *Creator of the Universe*, p. 97.

stereotypes of the insane [which] emphasize[d] characteristics, such as […] childishness'.[173] This assumption presents Wölfli as something 'other' than an autonomous, reasoning adult, and thus highlights an alleged lack or difference which sets him aside from mainstream society, his audience. However, this interpretation offers only a superficial perspective.

The significance of Wölfli's apparent 'naïve and child-like' perspective cannot be overlooked. Produced in 1910, this piece was constructed after fifteen years of continuous incarceration, often in isolation. However, in *Mental Asylum Band-Copse*, Wölfli presented himself as not only external to the asylum but also above it: he had transcended its space, and was able to offer his viewer an objective overview. There is an obvious power play here: despite his physical detainment, Wölfli cannot be exclusively contained in the context of the asylum.

The asylum itself is constructed like a fort, surrounded by turrets. Evoking ideas of surveillance and control, this construct is Foucauldian: forcing the 'patients' into a position of 'permanent visibility that assures the automatic functioning of power'.[174] Assembled with sombre shades of red and blue (as opposed to the array of colours used in *The Ballroom of Saint Adolf*), there is a suggestion of flames, perhaps to signify Hell. The faces of 'patients' appear to be merged with the architecture. Further examination reveals additional faces, they materialise with unnerving frequency: the viewer realises they are being watched; they are exposed; forced into a 'state of conscious […] visibility'.[175] Under the gaze of these emerging faces, the audience becomes the spectacle, rather than the observer. The watcher becomes the watched. The asylum interior is constructed as a labyrinth: one cannot discern the wall from the roof, or doors from windows. It is a space in which the self may be lost.

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[172] Carter-Park, 'Infinite Spaces', p. 200.
[173] Michael J. Clark, '"Morbid Introspection"', Unsoundness of Mind, and British Psychological Medicine, c. 1830-c. 1900', in *The Anatomy of Madness: Essays in the History of* Psychiatry, ed. by W.F. Bynum, Roy Porter and Michael Shepherd (London: Routledge, 2004), pp. 71-93 (p. 83).
[174] Foucault, *Discipline*, p. 201.
[175] Ibid.

Wölfli's characteristic merging of languages still features, as the work includes handwriting, musical notation and symbolism (particularly in the recurring cross imagery). However, both the writing and the notation only exist outside the asylum space. In the psychiatric environment, language is militant: it is a weapon exclusive to hegemonic forces, used to demarcate and silence the 'mad' 'other'. Thus, Wölfli could only access language outside the asylum. Writing and notation form a border to the piece, and are fundamental to the construction of the road which leads to the asylum: there is potential for a reading which would suggest that language *is* the path to incarceration.[176]

One cannot deny the impressive detail and artistic construction exhibited in each of Wölfli's pieces: they stand in contrast to Wieser's stark sketches. However, Wölfli's reception has not been universally positive: his 'otherness' poses too much of an obstacle for his work to exist in the mainstream art world where it has been described as 'unusual and strange'.[177] A psychiatric account of Wölfli's behaviour noted that 'his drawings are quite imbecilic, a chaotic jumble of notes, words, figures'.[178] Maclagan reported that 'several decades ago an advertisement for anti-psychotic medication reproduced a work by Wölfli'.[179] His work was deemed so 'other', so 'schizophrenic' that it could encourage consumerism: this image was held up as a warning to its audience that *you could end up experiencing 'reality' like this unless you are medicated*. Even the title of a favourable review draws attention to Wölfli's 'otherness' as something secondary to his talent, with Roberta Smith's art review referring to him as 'Crazy Like a Genius': he is *like* a genius, but his 'madness' is apparently beyond doubt.[180] Another review title argued that 'His Art *Emerged* From

[176] After all, if – as according to Hegel – 'cure must be sought in the re-externalization (rebirth) of the self […] through a path back to language', then 'madness' is demarcated by and apparent in a deviation from the 'path' of orthodox language (Berthold, 'Talking Cures', p. 306). Therefore, unorthodox language use is symptomatic of 'madness' and so a tumultuous relationship with semantics could result in incarceration.
[177] Carter-Park, 'Infinite Spaces', p. 207.
[178] Zemánková, *Wölfli: Creator of the Universe*, p. 13.
[179] Maclagan, *Outsider Art*, p. 43.
[180] Roberta Smith, 'Art Review: Crazy Like a Genius, a Weird, Foxy One', *The New York Times*, 28 February 2003

Madness'.[181] Wölfli's artistic credibility cannot seem to be separated from his 'madness': some of his art was even constructed using materials from the asylum, such as magazines. It appears that the art is an organic product of Wölfli's circumstances and, as he was incarcerated for over half of his life, it is inevitable that a social audience is unable to separate Wölfli's 'schizophrenic' and artistic identity. However, to what extent does this 'otherness' impact on the accessibility of Wölfli's narrative?

Wölfli's relationship with Morgenthaler apparently allowed him to be 'presented not as a clinical case […] but as an artist deserving his own presentation'.[182] Although Wölfli's 'madness' was never hidden (most significantly by his own presentation of asylum imagery), he was presented as Adolf Wölfli, rather than by means of a psychiatric pseudonym. His identity was not entirely dictated by psychiatry: his name endured, an obvious contrast to the insulting pseudonym ('Klotz') allocated to Klett. Predictably, Morgenthaler's attempt to present Wölfli as an artist rather than a 'patient' was 'ridiculed by the psychiatric community'.[183] Wölfli was not depicted as a psychiatric construct: his name represented something which kept him rooted in the realm of the familiar rather than the 'other'. By contrast, Klett and Wieser's identities had been entirely governed by Prinzhorn; they were not presented as artists (or even *human*) as their 'image-making' was incidental and thus secondary to their 'schizophrenia'. Is the difference between the three artists merely circumstantial, resting entirely on Morgenthaler's decision not to employ a pseudonym?

Although not entirely limited to a psychiatric identity, Morgenthaler did still introduce Wölfli as a kind of spectacle. The original publication of Morgenthaler's account was entitled *Ein Geisteskranker als Künstler*, translated as 'A Mentally Ill Person as an Artist'. Much like

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<http://www.nytimes.com/2003/02/28/arts/art-review-crazy-like-a-genius-a-weird-foxy-one.html> [accessed 1 February 2015].

[181] Kristine McKenna, 'Art Review: Adolf Wölfli: His Art Emerged from Madness', *The Los Angeles Times*, 25 September 1989 <http://articles.latimes.com/1989-09-25/entertainment/ca-36_1_adolf-wolfli> [accessed 1 February 2015]. Italics added for emphasis.

[182] Gilman, 'Madman as Artist', p. 587.

[183] Zemánková, *Wölfli: Creator of the Universe*, p. 28.

the title of Prinzhorn's work, Wölfli's 'madness' is the priority: his ability as an artist is second to his psychiatric environment and diagnosis. Here, in this initial and vitally important introduction which shapes the reader's perception and expectations, Wölfli's name is not mentioned, he is reduced to 'a mentally ill person'. This label is arguably worse than a pseudonym: it is generic, almost flippant, and suggests a total absence of individuality. Although Wölfli's work has been regarded as a cornerstone of Outsider Art, it cannot escape this psychiatric context. His art is perceived as a symptom of his 'madness', rather than a narrative. Through Wölfli's intricate designs, the viewer may reflect on the 'schizophrenic' mind in a general sense, but not receive and engage with Wölfli's narrative. Reviews laboriously outline points of departure from 'reality' evidenced throughout his work: stylistic features become symptomatic of his 'schizophrenia' rather than characteristics of Wölfli's art. Journalist, art critic and curator Kristine McKenna reflected that 'detailed renderings of elaborately developed systems are widely interpreted as his defense against his chaotically schizophrenic interior life'.[184] Wölfli's art is read as a symptom of his mental distress, rather than being received as a 'human document', worthy of acknowledgement and a different kind of engagement.

The social reception of Wölfli's work has been reliant on its context in the Outsider Art movement, which has given Wölfli a platform. However, this context inevitably denotes 'otherness' which prevents it from reaching a mainstream social audience. Peiry observed that, in a psychiatric environment, art is 'limited to itself […] only permitted to reflect the illness', and yet this also seems true of the Outsider Art movement.[185] Wölfli's art is bound to a context which inevitably renders it a spectacle. Under the label of the 'outsider', Wölfli's art will always be 'other', thus preventing his narrative from being heard in a mainstream context. As this residual 'otherness' apparently characterises the work of Wölfli, Wieser and

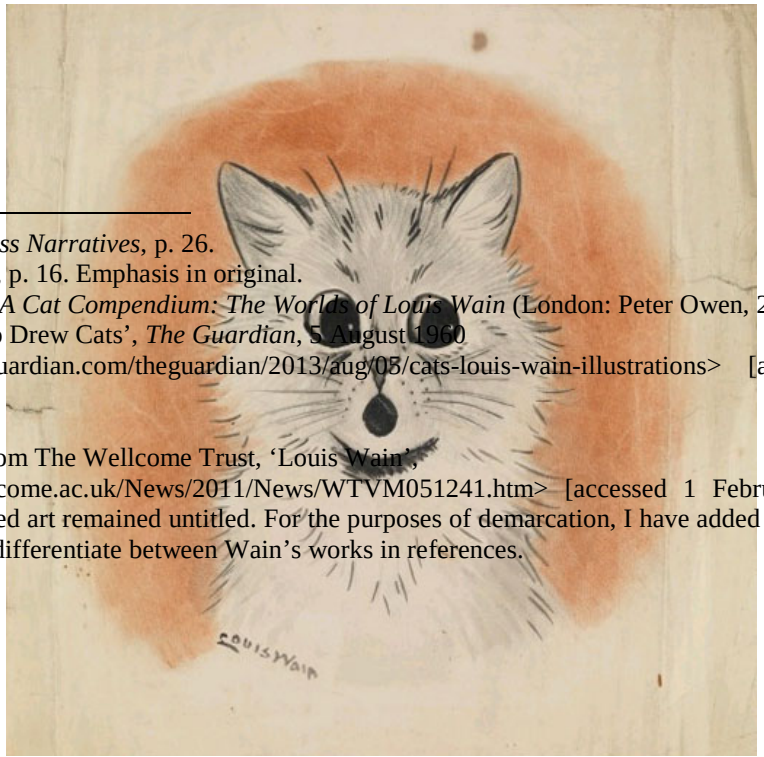
[184] McKenna, 'Art Review'.
[185] Peiry, *Art Brut*, p. 24.

Klett, it seems to be an inevitable aftermath of the initial psychiatric context which *re*produced their art. Because this art is deemed the product of a psychiatric environment, one can never escape the rhetoric which renders it a symptom rather than a narrative. The result is 'either stigma or social death'.[186] Although Outsider Art offers scope for limited social engagement, these narratives cannot escape the stigma enforced by their contact with psychiatry. Such narratives cannot be both 'other' and heard: in the words of Laing, 'the experience of *the other* is not evident to me, as it is not and never can be an experience of mine'.[187]

'A Quiet Little Man Drawing Cats': Louis Wain[188]

The art of Louis Wain offers a contrast to the work of Wölfli, Wieser and Klett. The success of Wain's early work is indisputable: *The Guardian* has described him as 'one of the most popular artists in the world for more than 30 years'.[189] British statesman Ramsay MacDonald reflected in 1925 that 'Louis Wain was on all our walls some 15 to 20 years ago […] Probably no artist has given a greater number of young people pleasure than he has'.[190] Wain's iconic anthropomorphic cats adorned the walls of nurseries, illustrated children's stories and were available in collectable postcard form.

Figure 6: Louis Wain, *Untitled (White Cat)*.[191]



[186] Kleinman, *Illness Narratives*, p. 26.
[187] Laing, *Politics*, p. 16. Emphasis in original.
[188] Peter Haining, *A Cat Compendium: The Worlds of Louis Wain* (London: Peter Owen, 2004), p. 39.
[189] 'The Man Who Drew Cats', *The Guardian*, 5 August 1960 <http://www.theguardian.com/theguardian/2013/aug/05/cats-louis-wain-illustrations> [accessed 1 February 2015].
[190] Ibid.
[191] Image taken from The Wellcome Trust, 'Louis Wain', <http://www.wellcome.ac.uk/News/2011/News/WTVM051241.htm> [accessed 1 February 2015]. Much of Wain's unpublished art remained untitled. For the purposes of demarcation, I have added short, descriptive titles in parentheses to differentiate between Wain's works in references.

Wain found a niche in the Victorian trend for anthropomorphised animals (demonstrated by the success of the likes of John Tenniel): he 'had no competitor in the field he had created'.[192] The supposed quaintness of Wain's early illustrations ensured mainstream success, although they displayed an obvious lack of realism and anatomical knowledge. *The Guardian* observed that 'the most damaging criticism of him was probably that of a child who was one of the few not delighted by his humour: "Mummy, those aren't cats, they haven't any bones"'.[193] However, the Great War significantly impacted on Wain's career as an artist – his success was particularly jeopardised by wartime paper shortage – and Wain's art swiftly lost its characteristic humour and playfulness.

'Troubled by financial difficulties and mental illness', Wain's behaviour became increasingly 'erratic and occasionally violent', resulting in his incarceration in 1924.[194] As demand for his work declined, Wain quickly fell into financial trouble, and was initially sent to the pauper ward of Springfield Mental Hospital in London. However, public appeals, led by the likes of H. G. Wells, generated 'thousands of pounds' which allowed Wain to spend the remainder of his life 'in a private room of a mental hospital near London'.[195] Wain has

[192] 'Man Who Drew Cats', *Guardian*.
[193] Ibid.
[194] Wellcome Trust, 'Louis Wain'.
[195] 'Man Who Drew Cats', *Guardian*.

subsequently been branded with the label of 'schizophrenia', often referred to as the 'schizophrenic cat painter', and his later work is believed to demonstrate a progressive break from 'reality', a typical 'psychotic' trait.[196] However, this diagnosis has since been challenged, with the Wellcome Trust suggesting that 'he had Asperger's syndrome and visual agnosia'.[197] Regardless of the label, Wain's artistic style changed, evolving into 'glittering and exotic webs of colour' and becoming increasingly abstract.[198] Despite this shift, Wain's work continued to depict his favoured motif: the cat.

Cats have been described as 'the most expressive of all animals', thus justifying Wain's anthropomorphism.[199] If we believe cats are animals of expression and personality, it is not necessarily a huge leap to imagine them with distinct characteristics and human traits. The cat has proven to be an ambiguous symbol: it can be indicative of a cosy, domestic environment, or it can signify something predatory. Cats are 'both gentle and sinister in appearance'.[200] There is an obvious link to the supernatural, with cats being the familiars of witches, associated with luck and fortune or linked to lunar cycles.[201] *The Guardian* speculated that Wain's use of the cat motif was 'to show how "human" cats were'.[202] Reviewers have argued that this theme of anthropomorphism is, in itself, representative of Wain's 'madness': 'these cats have just essentially been personified – Wain must have had a very troubled life indeed'.[203] However, it is much more likely that Wain's loyalty to the cat motif was a response both to contemporary trends for playful anthropomorphism and to the

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[196] Charles Nightingale, 'Projective Geometry in the Colour Drawings of H. P. Nightingale', *Leonardo*, 3 (Summer, 1973), 213-17 (p. 213).
[197] Wellcome Trust, 'Louis Wain'.
[198] Nightingale, 'Projective Geometry', p. 213.
[199] Edwin Evans, 'The Place and Function of Romanticism', *The Musical Times*, 1045 (March, 1930), 209-12 (p. 212).
[200] Hope B. Werness, *The Continuum Encyclopaedia of Animal Symbolism in Art* (London: Continuum, 2003), p. 72.
[201] In Egyptian culture, cats were associated with the moon, primarily due to their nocturnal existence. See Werness, *Animal Symbolism*, p. 74.
[202] 'Man Who Drew Cats', *Guardian*.
[203] Steff Lever, 'Communicating Through Cats Review', *London Confidential*, 21 September 2011 <http://www.londonconfidential.co.uk/Arts-and-Entertainment/Art/Communicating-Through-Cats-Review> [accessed 1 February 2015].

comfort he found, after the death of his wife, Emily, in his feline companion, Peter, 'a black-and-white kitten'.[204]

Regardless of the symbolism latent in Wain's repetition, the cat motif does aid a comparison of his earlier and later works. The content rarely changes, merely the execution. Maclagan argued that such repetition is symptomatic of psychotic art, as it is 'marked by a constant returning to the same motifs and an intense elaboration of them'.[205] However, it is difficult to place Wain's work in any sort of chronological order to reveal progression or gradual change. Psychiatric discourses and popular culture have arranged Wain's work into a sequence which allegedly reveals the development of his 'schizophrenia', however, it is impossible to verify the order of production. Wain's work was rarely dated unless it was published, making it difficult to correlate any changes in style to a certain period of his life. However, for the purpose of my analysis, I will examine Wain's work in the sequence in which it most often appears: that of the alleged 'progressive escape of reality towards delusion' which characterises the development of 'psychosis'.[206] This is how Wain's work is presented most frequently, and thus is the manner in which his narrative has been reconfigured and received.

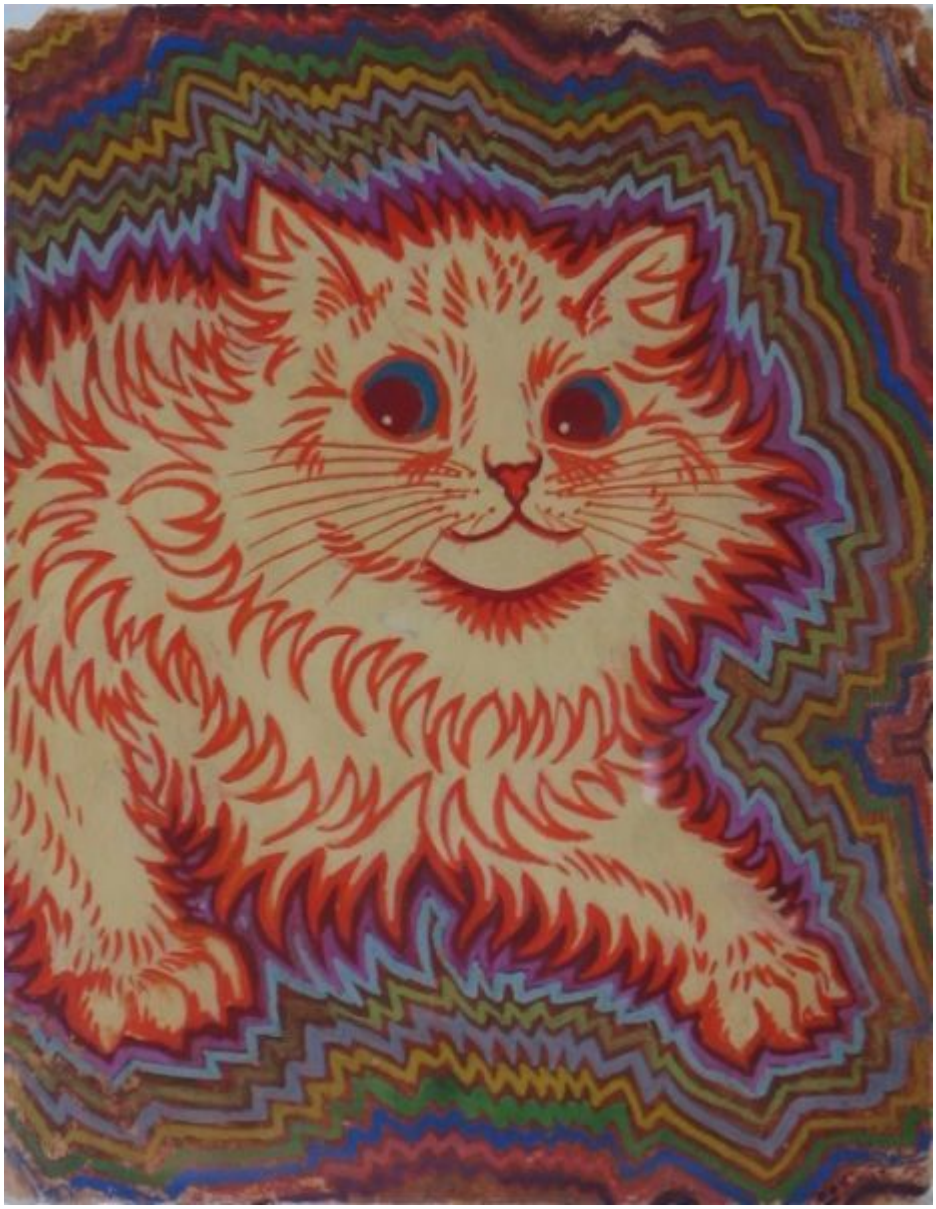
[204] 'Man Who Drew Cats', *Guardian*.
[205] Maclagan, *Outsider Art*, p. 81.
[206] Cardoso, 'Progression of Psychosis'.

Figure 7: Louis Wain, *Untitled (Realistic Cat)*.[207]

Figure 7 demonstrates an early example of Wain's work, striking in its realism: the perspective is faultless, the colours true-to-life and the attention to detail depicts a texture reminiscent of fur. A viewer is able to recognise that *this is a cat*. This is a prime example of imitative art, 'the action or practice of imitating or copying'.[208] Wain has depicted something familiar in a familiar way, and is thus able to enter collective discourse as the viewer is able to recognise and share Wain's perspective.

[207] Image taken from Dangerous Minds, 'The Psychedelic Madness of Louis Wain's Cats' <http://dangerousminds.net/comments/the_psychedelic_madness_of_louis_wains_cats> [accessed 1 February 2015].
[208] *OED*, 'imitation'.

Figure 8: Louis Wain, *Untitled (Cat with Aura)*, gouache, 22.6 × 17.5cm.[209]



Later examples of Wain's work move away from the imitative and towards the unfamiliar. This shift is gradual, if we follow the sequence in which these images most frequently appear. These three images (Figures 8-10) have been used as paradigmatic examples of the 'progressive escape of reality towards delusion' which apparently reveals the development of the 'schizophrenic' condition.[210] Biographer Peter Haining reported that 'many of the pictures [produced by Wain following his incarceration] revealed the state of his

[209] Image taken from Bethlem Heritage, 'Louis Wain Gallery' <http://www.bethlemheritage.org.uk/gallery/pages/LDBTH157.asp> [accessed 18 November 2010].
[210] Cardoso, 'Progression of Psychosis'.

increasing schizophrenia'.[211] These cats represent Wain's gradual point of departure from shared social symbols and exchange between artist and audience. The painting in Figure 8 still conforms to certain social codes which allow it to be identified as a cat: it has a feline structure; it has a texture reminiscent of fur; it has the salient features (triangular ears, large eyes, the arrangement of the nose and mouth) which allow a social audience to recognise that the subject matter is a cat. The colouring of the piece suggests a slight point of departure: the subdued, accurate colouring from his earlier work has been lost to bold and bright colours which surround the cat like an aura.

Figure 9: Louis Wain, *Untitled (Owl-Like Cat)*, coloured pencils, 22.8 × 17.6cm.[212]

The subsequent image (Figure 9) still features certain codes which, socially, allow the subject to be identified as a feline. The triangular ears protrude clearly from a vaguely spherical shape which

[211] Haining, *A Cat Compendium*, p. 40.
[212] Image taken from Bethlem Heritage, 'Louis Wain'.

corresponds to the head of the animal. The wide eyes remain, positioned above the arrangement of the nose and mouth which is distinctly feline. However, the image as a whole has become increasingly abstract: the catlike structure is overwhelmed by a confused, equivocal composition of shapes and patterns. There is no clear structure at all besides the head; it is lost behind the intense, haunting and almost owl-like glare of the cat. The increasingly abstract nature of Wain's work 'represents an ongoing restructuring of a discursive consciousness, a consciousness that differs sharply from our own sense of reality', demonstrating a struggle between the abstract and the 'real'.[213] Wain's work balances on the border of social validation/invalidation; shared symbols are present, but there is an evident move away from the familiar which threatens to place his later art beyond social interpretation. To return to Maclagan's suggestion that psychotic art is 'marked by a constant returning to the same motifs and an intense elaboration of them', in this collection of images, Wain's focus on cat imagery never wavers, but his approach has evolved; his perspective altered.[214]

It would, of course, be easy to assume that this change in perception is a direct result of Wain's fractured 'reality', and to accept this abstract art as a sign of his increasing 'otherness'. However, it is an oversimplification to see this art as representative of Wain's 'schizophrenia' impairing his perception of the world. Instead, these images can be read as Wain throwing out conventional narrative structures (such as the imitative art featured in Figure 7) in favour of something more authentic. Wain's experience of 'madness' cannot be contained in the realm of the familiar, and so he inevitably gravitated towards the unfamiliar and the abstract to find a space in which he could formulate his narrative. However, the abstract is only unfamiliar because 'madness' had not been allowed a voice. Socially, we do not recognise a language of 'madness': we only have and know a language *about* it. Art

[213] Carter-Park, 'Infinite Spaces', p. 193.
[214] Maclagan, *Outsider Art*, p. 81.

allegedly ‘helps sustain society [because it ensures] that no man is an island’, however the romantic notion that art is all encompassing and universally accessible (to both the artist and audience) does not seem to accommodate ‘mad’ art.[215] If art is a universal narrative structure, designed to connect artist and audience – to ‘communicate […] emotion between a creator and an audience’[216] – why has it rendered Wain’s work a spectacle, ‘a bit strange’, suitable only for ‘a niche audience’?[217]

Figure 10: Louis Wain, *Untitled (Kaleidoscope Cat)*, gouache, 22.5 × 17.1cm.[218]

The final piece in the series of images (Figure 10) demonstrates a clear point of departure from any socially

[215] Goodman, *Languages*, p. 257.
[216] Wartenberg, *Nature of Art*, p. 8.
[217] Lever, ‘Communicating Through Cats’.
[218] Image taken from Bethlem Heritage, ‘Louis Wain’.

shared symbols. Wain has not represented the cat in a way which is familiar: perhaps the only feline features which remain are the shape and positioning of the ears. This is not a cat which could be definitively recognised as such in a social context. As detailed by Saussure, society relies on receiving a series of signifiers (such as the feline structure, large, spherical eyes and triangular nose) in order to identify something. The colours are lurid and bold, demonstrating a total rejection of the realistic, innocuous colouring of the earlier piece. The structure of the subject is chaotic, formulated out of abstract shapes and patterns. The eyes, no longer spherical and wide, have metamorphosed into triangles; the change in shape has altered the personality of the cat motif. The subject has become threatening; where one would expect a petite feline mouth (were one to superimpose the social codes and expectations of what a cat 'should' look like), one finds instead a serrated crescent, indicative of a sinister grin. Wain moved away from the realm of shared symbols, communicating his own experience of 'reality'; his own creation, although socially invalidated as an 'abstract' piece, has embodied Wain's 'private world in concrete form'.[219]

The sequence of these images has been imposed to show a progressive break from 'reality' (and thus 'otherness'). However, they could just as easily represent artistic experimentation in the face of change. Psychiatric discourse disregards these images as symptomatic of 'otherness', a product of Wain's 'madness', rather than as an attempt to represent it. Evidence does exist to deconstruct the mainstream assumption that Wain's later art depicts the progression of his 'schizophrenia': a handful of dated images suggest that Wain was still producing using his characteristic, cartoonish style even after his incarceration.

[219] Carter-Park, 'Infinite Spaces', p. 195.

Figure 11: Louis Wain, *Blue Cat*, 1932.[220]

Dated 1932, *Blue Cat* conforms to shared social signifiers which allow it to be identified as a cat. The only point of departure is the colour, however, its subtle shade prevents it from being the focal point of the image.[221]

Although Wain has not been explicitly documented in a psychiatric publication (as Wieser, Klett and Wölfli all were), hegemonic discourse has still imposed itself on his work. *The Guardian* observed that 'his later pictures made in a mental hospital have been collected for a different reason […] the familiar friendly cats changed into increasingly elaborate patterns with the progress of his illness'.[222] The psychiatric enforcement of 'otherness' has retrospectively reclaimed Wain's work, ensuring that mainstream society perceives it as 'the

[220] Image taken from Outsider Art, 'Louis Wain' <http://www.outsiderart.co.uk/wain.htm> [accessed 2 February 2015].

[221] The title might suggest a point of departure from mainstream society by denoting an experience of 'depression'. Use of the term 'blue' to signify a state of 'depress[ion], low-spirit[s] [and] sorrow' was ingrained enough in the vernacular of the 1930s for it to feature prominently in the classic popular song, 'Blue Moon' (written by Richard Rodgers and Lorenz Hart in 1934). See *OED*, 'blue' <http://www.oed.com/view/Entry/20577?rskey=BimXKq&result=1&isAdvanced=false#eid> [accessed 16 June 2016].

[222] 'Man Who Drew Cats', *Guardian*.

progress of his illness' rather than the progress of his artistic style. They are 'classic examples of schizophrenic art': these images are only permitted to reflect and objectify Wain's 'schizophrenia'; nothing more.[223] Despite the popularity of Wain's earlier work, anything produced following his incarceration has been tainted by his 'madness', and thus can be read as nothing more than his 'otherness'. Wain's contact with psychiatry has prevailed: it enforces silence, as 'several generations have now grown up to whom his name means nothing'.[224]

'In Thee Burns the Fire of Genius': Richard Dadd[225]

Born in 1817, Richard Dadd pursued a career as a professional artist in an 'orthodox manner, entering the Academy Schools in 1837 and in the same year exhibiting for the first time'.[226] Following the tradition of imitative art, Dadd's education consisted of 'copy[ing] from the life model or from the Old Masters', leading to his early oeuvre consisting primarily of conventional portraits which display superb technical ability but little originality.[227] These stand in stark contrast to his later work, which favoured the fantastical over the familiar. Dadd's identity as a professional artist sets him aside from the artists I have covered so far: his inclusion, and training, in academy culture serves to situate him firmly as an Artist.

Dadd's work is entrenched in the canon of the art world, reported as having 'a striking influence on future artists'.[228] In particular, Dadd's fantastical art has been revered, with *The Fairy Feller's Master-Stroke* (Figure 12) being 'generally considered to be Dadd's

[223] 'Man Who Drew Cats', *Guardian*.
[224] Ibid.
[225] Nicholas Tromans, *Richard Dadd: The Artist and The Asylum* (London: Tate, 2011), p. 19.
[226] Tromans, *Richard Dadd*, p. 11.
[227] Ibid.
[228] A.S. Byatt, 'Richard Dadd: The Fairy King', *The Guardian*, 2 September 2011 <http://www.theguardian.com/artanddesign/2011/sep/02/richard-dadd-fairy-king-byatt> [accessed 2 February 2015].

masterpiece'.[229] Dadd's legacy as an artist has endured; he has been 'acknowledged as an important British artist whose work hangs in the British Museum and the V&A'.[230] Unlike the work of Wölfli and Klett, Dadd's work has surpassed the label of Outsider Art.[231] Dadd's ability to 'harness a magnificent, other-worldly imagination' seems to have ensured the longevity of his work.[232] Does Dadd's art represent the potential for 'mad' art to be *heeded* as a narrative? How does Dadd's experience of 'madness' coexist with his esteemed artistic reputation?

Figure 12: Richard Dadd, *The Fairy Feller's Master-Stroke*, 1855-64, oil on canvas, 54 × 39.4cm.[233]

[229] Tate, *The Fairy Feller's Master-Stroke* <http://www.tate.org.uk/art/artworks/dadd-the-fairy-fellers-master-stroke-t00598/text-summary> [accessed 2 February 2015].
[230] 'Richard Dadd: Masterpieces of the Asylum' *The Independent*, 30 August 2011 <http://www.independent.co.uk/arts-entertainment/art/features/richard-dadd-masterpieces-of-the-asylum-2345818.html> [accessed 2 February 2015].
[231] Dadd's capacity as a professional artist rendered the label of Outsider Art inapplicable: by virtue of formally training to be an accomplished artist, Dadd was self-consciously an Artist.
[232] 'Dadd: Masterpieces', *Independent*.
[233] Image taken from Tate, *Fairy Feller's Master-Stroke*.

The trajectory of Dadd's artistic career led him to undertake a tour of the Middle East with his patron Sir Thomas Phillips. Dadd 'was expected to make drawings of the places they visited' in return for Phillips covering the cost of his travel and expenses.[234] However, Dadd struggled to fulfil this role, complaining that 'they never stopped long enough for him to draw what he saw'.[235] Despite these frustrations, this tour did seem to broaden Dadd's artistic and sensory horizons, with him recording in a letter that 'I had the most unaccountable impulses, that would not let me stop to sketch, but were constantly prompting me on, to drink in […] the stream of new sensations'.[236] On his return, however, Dadd began to exhibit 'signs of mental disturbance', although, for the most part, this appears to have been interpreted as sunstroke.[237] Dadd 'warily controlled his conversation' in an attempt to keep rumours of his altering mental state at bay.[238] However, the period that follows does, indeed, suggest that this was the genesis of Dadd's intense paranoia and thus his 'madness'. Could this perhaps suggest that Dadd's heightened sensory experiences abroad were something other than just a response to his new environment?

Concerned for his son, Dadd's father, Robert, discreetly sought psychiatric advice from Dr Alexander Sutherland, who reported that the young man 'was dangerous and urgently needed quiet and care'.[239] Robert Dadd decided to take his son travelling in an attempt to remove him from the stress of this barren period in his career (Dadd's recent work had been described as 'spiritless and poor' by his peers).[240] While in Cobham, on the 28th August 1843, 'Dadd stabbed and killed his father – the attack was obviously premeditated, as Dadd had prepared his flight out of the country […] He claimed to be controlled by demons,

[234] Tromans, *Richard Dadd*, pp. 36-37.
[235] Byatt, 'Richard Dadd'.
[236] Tromans, *Richard Dadd*, p. 51.
[237] Byatt, 'Richard Dadd'.
[238] Tromans, *Richard Dadd*, p. 54.
[239] Tromans, *Richard Dadd*, p. 60.
[240] Ibid.

and that his father was not his real father'.[241] After fleeing to Calais and assaulting a fellow passenger while travelling to Paris, Dadd was taken into custody.

Dadd was deemed a 'criminal lunatic', a new psychiatric/legal category resulting from the Criminal Lunatics Act of 1800. Admitted to Bethlem Hospital after his trial, Dadd explained that the murder was a result of him believing that his father was an 'imposter, for [his] true father was the Egyptian god Osiris'.[242] Alienists recorded Dadd's diagnostic label as 'insane', however, the label of 'schizophrenia' (a term not in general usage at the time of Dadd's incarceration) has been retrospectively imposed on Dadd by historians and art critics alike.[243] Dadd spent the remaining forty-three years of his life incarcerated, moving from Bethlem to Broadmoor in 1864: circumstances which inevitably impacted on Dadd's work, both in terms of his experiences and his access to resources.

However, art historian Nicolas Tromans observed a disconnect between Dadd's life and his art: 'the factual approach to Dadd's life and the appeal he had offered to fantasy and imagination did not seem to be compatible'.[244] Tromans explained that presenting biographical information alongside Dadd's work (as featured in a 1974 Tate Gallery exhibition) caused Dadd's aesthetic appeal to 'subside', and 'derailed' academic and societal interest in Dadd's work.[245] It is apparent that interest in Dadd as an artist – and his role as a professional Artist – was not sustainable in light of his 'madness': a conflict also evident in the work of Wölfli, Klett, Wieser and Wain, as these artists were unable to be received as artists due to their psychiatric context. This was also a contemporary issue, with Dadd's peers continuously citing 'sunstroke' as the cause of the change in his health and behaviour, even

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[241] Byatt, 'Richard Dadd'.
[242] Tromans, *Richard Dadd*, p. 60. Dadd's conviction that his father was an imposter echoes the twentieth century label of 'Capgras syndrome' – first described in 1923 – which 'is a rare condition in which a person insists that a person they are close to […] has been replaced by an impostor'. See Helen Thomson, 'Imposter Disorder Explains How Man's Wife Was "Stolen"', *New Scientist*, 5 November 2014 <https://www.newscientist.com/article/mg22429944-700-imposter-disorder-explains-how-mans-wife-was-stolen> [accessed 13 February 2016].
[243] See Tromans, *Richard Dadd*, pp. 78-79.
[244] Tromans, *Richard Dadd*, p. 6.
[245] Ibid.

after his incarceration, revealing a desire to excuse Dadd's suffering as a physical ailment and thus not acknowledge his 'madness'.[246]

Removed from the mainstream reluctance to view Dadd's art as a reflection on his experiences, his work can be read as a narrative of the self struggling in a hostile psychiatric environment. In addition to the escapism evident throughout Dadd's fantastical landscapes (which would later be echoed in Wölfli's creation of an internal universe), Dadd created a series of images entitled *Passions*. These represent an attempt to *de*medicalise the self. The images parodied the tradition initiated by physician Philippe Pinel, who created 'the first atlas of the appearance of the insane'.[247] The nineteenth-century rise in phrenology sought to 'discern the outward marks of a mind' on the physical self.[248] Thus, asylum illustrations and, later, asylum photography, would offer illustrations of what a certain type of 'madness' looked like. They were designed to encapsulate 'the singular expression arising from morbid movements of the mind', pinning down 'madness' to a particular pattern of facial expressions, body language and posture.[249]

The idea of the 'passions' is tightly bound to the Ancient Greek notion of the 'humours': 'the passions had classically played the role of conduit between the soul and the body'.[250] In the case of 'madness', they were used in an attempt to pin down difference, in order to establish a rupture between the soul and body which could account for mental illness. Tromans reflects that 'in nineteenth-century asylum medicine, the passions took on an urgent new role as the potential bridge between the split aspects of a patient'.[251] Dadd responded to this psychiatric quest for an anomaly by constructing his own language, his own

[246] Tromans, *Richard Dadd*, p. 82.
[247] Gilman, *Seeing the Insane*, p. 79.
[248] Conolly, 'Physiognomy', p. 19. This has been an enduring human preoccupation; see *Macbeth*: 'There's no art/ To find the mind's construction in the face'. William Shakespeare, *Macbeth*, in *Complete Works*, ed. by Jonathan Bate and Eric Rasmussen (London: Macmillan, 2007), I. 4. 11-12.
[249] Conolly, 'Physiognomy', in *Embodied Selves*, p. 19.
[250] Tromans, *Richard Dadd*, p. 114.
[251] Ibid.

interpretation of the ‘passions’ which are apparently fundamental to how the self is constructed.

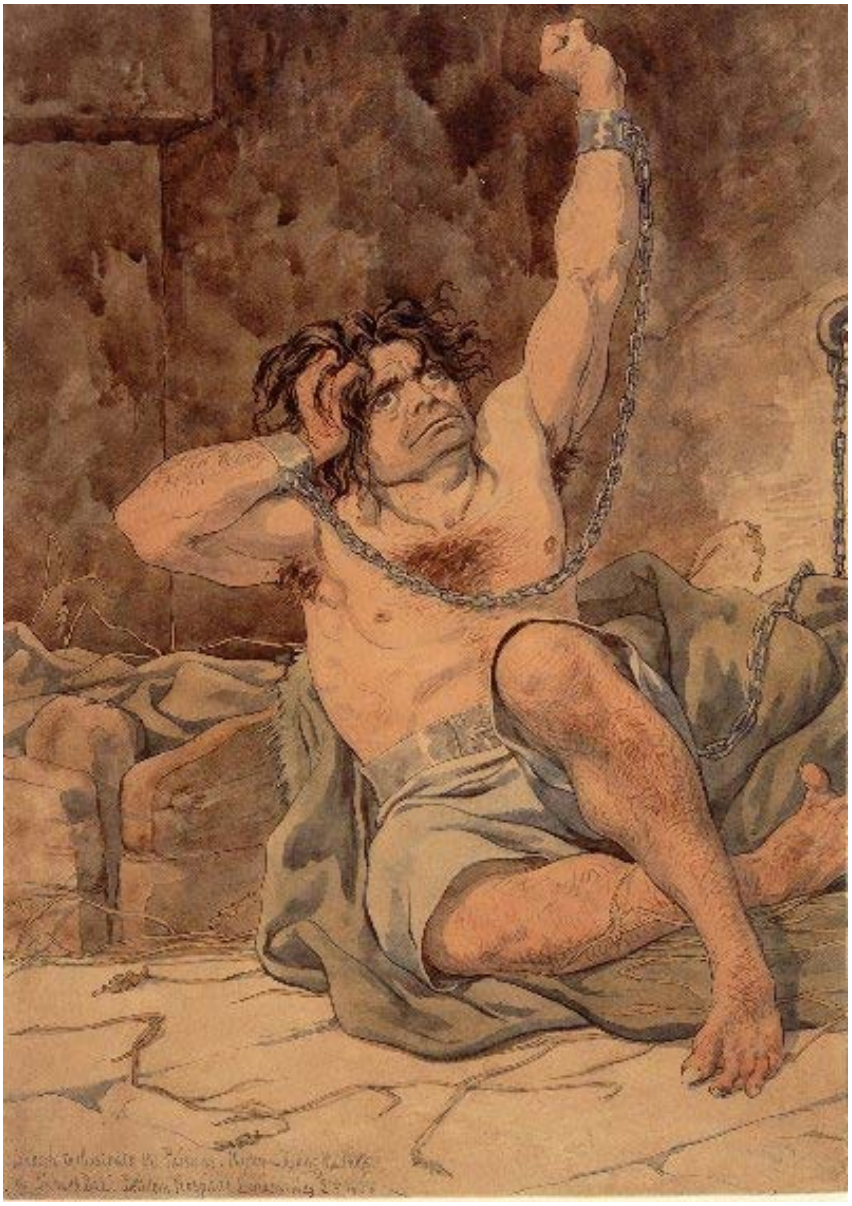
Figure 13: Richard Dadd, *Sketch to Illustrate the Passions: Grief or Sorrow*, 1854, watercolour, 35.2 × 25cm.[252]

Figure 13 takes grief and sorrow out of the psychiatric realm of melancholia and into the sphere of human emotion. By presenting sorrow as a response to death, signified by the skull and the ornate headstone, it is familiarised. These emotions are no longer symptomatic of

[252] Image scanned from Tromans, *Richard Dadd*, p. 116.

'madness' but indicative of circumstances; something transient, rather than something reflecting the make-up of the individual.

Figure 14: Richard Dadd, *Sketch to Illustrate the Passions: Agony – Raving Madness*, 1854, watercolour on brown paper, 35.2 × 25cm.[253]



A superficial interpretation of *Sketch to Illustrate the Passions: Agony – Raving Madness* could lead to a suggestion that Dadd is supporting psychiatric discourse. Here, the 'mad' individual must be physically detained, presumably because they embody the potential for violence. However, the 'diagnosis' given in the title – 'Agony – Raving Madness' –

[253] Image scanned from Tromans, *Richard Dadd*, p. 129.

suggests an internal, rather than external, struggle. 'Agony' denotes physical suffering: it is a hyperbolic, emotive term. As the image depicts a figure in chains, the viewer assumes that this 'agony' is not related to his mental state, but rather his physical (mis)treatment at the hands of alienists. It is unlikely that a figure in 'agony' is able to pose any form of physical threat. Further, 'raving' reflects 'mainline views in psychiatric medicine […] it became standard to refer to what mad people said […] through terms such as "chattering", "jabbering" and "ranting"'.[254] However, it is a reference to the *vocal* rather than the *physical*, and, again, does not immediately denote a threat of violence. Although, to an extent, the visual theme of incarceration does support hegemonic narratives, Dadd has undermined the psychiatric assumption that 'madness' needs to be restrained and controlled. He forces his viewers to challenge what they see.

Further investigation supports the idea that Dadd was encouraging his viewer to question the legitimacy of the act of detainment. Despite being well-built, the figure is rendered passive: he is on the floor, rather than straining at his chains in a bid to escape or attack those around him. He wears a forlorn expression, denoting vulnerability rather than aggression. His head is supported by one of his hands, reminiscent, in our twenty-first-century context, of the clichéd 'stock' image of an individual clutching their head to imply mental distress.[255] This is a common motif in visual representations of 'madness', as exhibited in the likes of Van Gogh's *At Eternity's Gate*, Albrecht Dürer's *Melancholia* and Edvard Munch's *Scream*. The general impression is of helplessness, rather than ferocity. An interesting point of comparison can be found in an illustration by anatomist Charles Bell, featured in *Anatomy: Expression in Painting*:

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[254] Porter, *Social History*, p. 32.

[255] For a twenty-first century perspective on 'the head clutcher', see Sectioned, 'What Does Mental Illness Look Like? The Head Clutcher' <https://sectioneduk.wordpress.com/2013/05/31/what-does-mental-illness-look-like-the-head-clutcher/> [accessed 9 February 2015]. Time to Change have recently protested against this stigmatising and homogenised representation of mental illness with their 'Get the Picture' campaign: see Time to Change, 'Get the Picture' <http://www.time-to-change.org.uk/getthepicture> [accessed 13 February 2016].

Figure 15: Charles Bell, *Madness*, 1806.[256]

The *mise-en-scène* is almost identical: the viewer is confronted with the spectacle of a 'madman' in chains. However, Bell's illustration 'follows the view that the depiction of insanity is related to […] fear and terror'.[257] The snarling facial expression and hostile body language denote aggression: this 'madness' is to be feared, rather than empathised with. In this image, Bell argued that physical detainment is justified, even necessary. However, Dadd's illustration, created nearly fifty years later, presents the viewer with a scene which is considerably more complex. It is not as easy to 'other' the figure in Dadd's painting.

Through the *Passions*, Dadd exposed the myriad shades which lie between 'madness' and 'sanity'. By reclaiming 'sorrow' and 'agony' from psychiatric vocabulary and depicting them as human emotions rather than medicalised phenomena, Dadd argued that 'madness' is an experience worthy of empathy. These illustrations offer the potential to challenge

[256] Image taken from Charles Bell, *Anatomy: Expressions in Painting* (London: Longman, 1806), p. 153.
[257] Gilman, *Seeing the Insane*, p. 91.

hegemonic narratives by inviting the viewer to reflect on the treatment of a 'madman' (Figure 14), and more generally on the means used to justify this treatment. If we can relate to the 'passions' which allegedly reveal 'madness', does that make us 'mad', too? Or does it render the 'madman' 'sane'? In theory, Dadd's context as part of the mainstream art world grants him a voice: unlike Wölfli and Klett, Dadd is not limited to the role of 'outsider' as he has transcended the Outsider Art genre. However, Dadd's radical counter-narrative has either not been received as such or has not been heard at all.

For Wölfli, Klett, Wieser and Wain, the psychiatric context portrayed their art as inaccessible, and prevented them from being celebrated as artists. With Dadd, the situation is subverted. The aesthetic value of Dadd's work has been divorced from his 'madness': it 'did not seem to be compatible'.[258] The reluctance to read Dadd's work as a product of his experiences suggests that the art world cannot accept Dadd as a 'mad' artist: he must be an artist, or he must be 'mad', he *cannot* occupy both spaces. The silencing of Dadd's biography has allowed his art to reach a wide audience. However, his work cannot be read as a powerful counter-narrative if the psychiatric context remains unacknowledged. Dadd's work exists in the canon: when *tainted* with Dadd's 'otherness', it causes appeal to 'subside', and 'derail[s]' interest.[259] It is becoming increasingly apparent that the romantic notion of a 'mad' artist itself is a paradox: one may be 'mad' *or* one may be an artist. Art can be read as a symptom of 'madness' or art can be interpreted for its aesthetic value. In the world of mainstream art, it appears that there is no space for 'mad' art.

'Genius Roams Along Such Mysterious Paths': Vincent Van Gogh[260]

One cannot question Van Gogh's reputation as an artist. The popularity of his iconic *Sunflowers* has endured: as art historian Martin Gayford observed, 'the patch of floor in front

[258] Tromans, *Richard Dadd*, p. 6.
[259] Ibid.
[260] Steven Naifeh and Gregory White Smith, *Van Gogh: The Life* (London: Profile, 2011), p. 4.

of it "gets more scuffed" than that in front of any other work in the National Gallery'.[261] Van Gogh's 'masterpieces' are almost universally celebrated.[262] Extensive academic interest has ensured that Van Gogh's life and letters have been widely disseminated, too, reminiscent of his own interest in the biographies of artists: 'I pay as much attention to the man who does the work as to the work itself'.[263] Van Gogh desired his work to be read as an *extension* or *mirror* of the self: 'as my work is […] so am I'.[264] Art is a narrative, a reflection of the experiences of the artist. With this in mind, it would appear that Van Gogh is well-placed to be heard: his popularity, and his deliberate merging of art and artist, suggest that his 'madness' narrative is both acknowledged as a product of his experiences, and received by a mainstream audience.

Van Gogh's work has been commended for its originality. French dramatist and poet Antonin Artaud observed: 'For a long time pure linear painting drove me mad until I met Van Gogh, who painted neither lines nor shapes but inert things in nature as if they were having convulsions'.[265] Van Gogh's style stands out as an anomaly in the nineteenth-century tradition of the 'linear' and the imitative, and this may account for the underwhelming reception of his work in the nineteenth century. His radical style meant that 'he was not widely appreciated during his lifetime', although his work later found a space in the Post-

[261] Martin Gayford, 'Van Gogh's *Sunflowers*: the Story Behind a Masterpiece', *The Telegraph*, 24 January 2015 <http://www.telegraph.co.uk/culture/art/art-features/10592710/Van-Goghs-Sunflowers-the-story-behind-a-masterpiece.html> [accessed 4 February 2015].
[262] Martin Coomer, 'Vincent Van Gogh: *The Sunflowers*', *Time Out*, 28 November 2014 <http://www.timeout.com/london/art/vincent-van-gogh-the-sunflowers> [accessed 4 February 2015].
[263] Naifeh, *Van Gogh*, p. 6.
[264] Ibid.
[265] Antonin Artaud, 'Van Gogh: The Man Suicided by Society', in *Artaud Anthology*, ed. by Lawrence Ferlinghetti and Nancy J. Peters (San Francisco: City Light Books, 1965), pp. 135-63 (p. 140). Artaud's description immediately evokes the narrator in Perkins Gilman's *The Yellow Wallpaper*. She describes the 'sprawling flamboyant patterns' in the wallpaper which resist linearity, and 'plunge off at outrageous angles, destroy themselves in unheard of contradictions'. See Perkins Gilman, *Yellow Wallpaper*, p. 13.

Impressionist movement after being exhibited alongside the likes of Cezanne, Gauguin and Seurat in 1910.[266]

Van Gogh started painting in 1883, and his career as an artist was tragically brief. He was incarcerated in 1889, and died the following year.[267] Although his letters suggest he suffered reoccurring bouts of 'depression' throughout his life, 'Vincent had always managed to pull himself out of the abyss'.[268] Van Gogh's act of self-harm seems to be the first explicit, external sign of a mind that could no longer cope.[269] Prior to this, his erratic behaviour had been perceived as incidental to his artistic temperament, as something which *validated* his chosen profession: he observed that 'the more sick and fragmented I am, the more I become an artist', thus merging his 'madness' with his artistic credibility.[270] Previous incidents of self-destructive behaviour had been less overt, too closely linked to his eccentric lifestyle, ranging from his tumultuous relationship with alcohol and prostitutes (and the resulting poverty), and a tendency to refuse food. Van Gogh was hospitalised following the amputation of his own ear. His brother, Theo, reflected that 'his suffering is deep and hard for him to bear […] nothing can be done to relieve his anguish now'.[271] This seems to be the point where Van Gogh's 'eccentricity' became something which could no longer be self-managed: rather than signifying his identity as an artist, his behaviour became symptomatic of 'madness'.

Although Van Gogh temporarily returned to his lodgings in Arles following his hospitalisation, the community rejected him. His behaviour now fell 'on the wrong side of a

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[266] The National Gallery <http://www.nationalgallery.org.uk/artists/vincent-van-gogh> [accessed 4 February 2015].
[267] The dominant assumption that Van Gogh died from suicide has recently been challenged: I will address this alternative narrative later on.
[268] Naifeh, *Van Gogh*, p. 703.
[269] For a detailed account of the circumstances which led to, and followed, Van Gogh's removal of his own ear, see Naifeh, *Van Gogh*, pp. 701-04.
[270] Van Gogh, quoted in McKay, 'Art, Madness', p. 413.
[271] Naifeh, *Van Gogh*, p. 707.

dividing line' which arbitrarily separates 'madness' and 'sanity'.[272] He was dubbed 'the queer painter' by the local children, referred to as '"*fou roux*" – the mad redhead' in brothels, and, when locals encountered him, 'they tapped their heads and muttered to each other "*fada*" – Midi dialect for "crazy"'.[273] A petition was formed and signed to have him committed to a mental asylum 'in the name of public security'.[274] Van Gogh was taken to an isolation cell in Arles Hospital for observation. His inability to produce art during this period further enforced his sense of desperation. He noted 'I *miss* the work […] the work takes my mind off things, or rather keeps me in order'.[275] His art represented a refuge, a method of self-management in the face of chaos.

Van Gogh eventually admitted himself to the asylum of Saint-Paul De Mausole, which 'operated more like a resort than an asylum', the antithesis to the isolation cells which had prevented him from working.[276] Therapeutic rituals, coupled with scenic views, calmed him and aided his productivity. He was diagnosed as suffering from 'acute mania with generalized delirium', and his treatment comprised doses of bromide, long baths, regular meals and small rations of wine: a routine of self-care which had previously been lacking during Van Gogh's self-destructive periods.[277] In this asylum space, Van Gogh found compassion, as opposed to the hostility exhibited by mainstream society, not least in his own community. His letters exhibit a sense of tranquillity, and he produced some of his most iconic and imaginative work in the walls of the Saint-Paul De Mausole asylum. *The Starry Night*, hailed as one of his 'atmospheric epiphanies', was produced in June 1889, shortly after his admission.[278]

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[272] Foucault , *History of Madness*, p. 101.
[273] Naifeh, *Van Gogh*, p. 727.
[274] Ibid.
[275] Naifeh, *Van Gogh*, p. 730. Emphasis in original.
[276] Naifeh, *Van Gogh*, p. 746.
[277] Naifeh, *Van Gogh*, p. 749.
[278]Artaud, 'Van Gogh', p. 141.

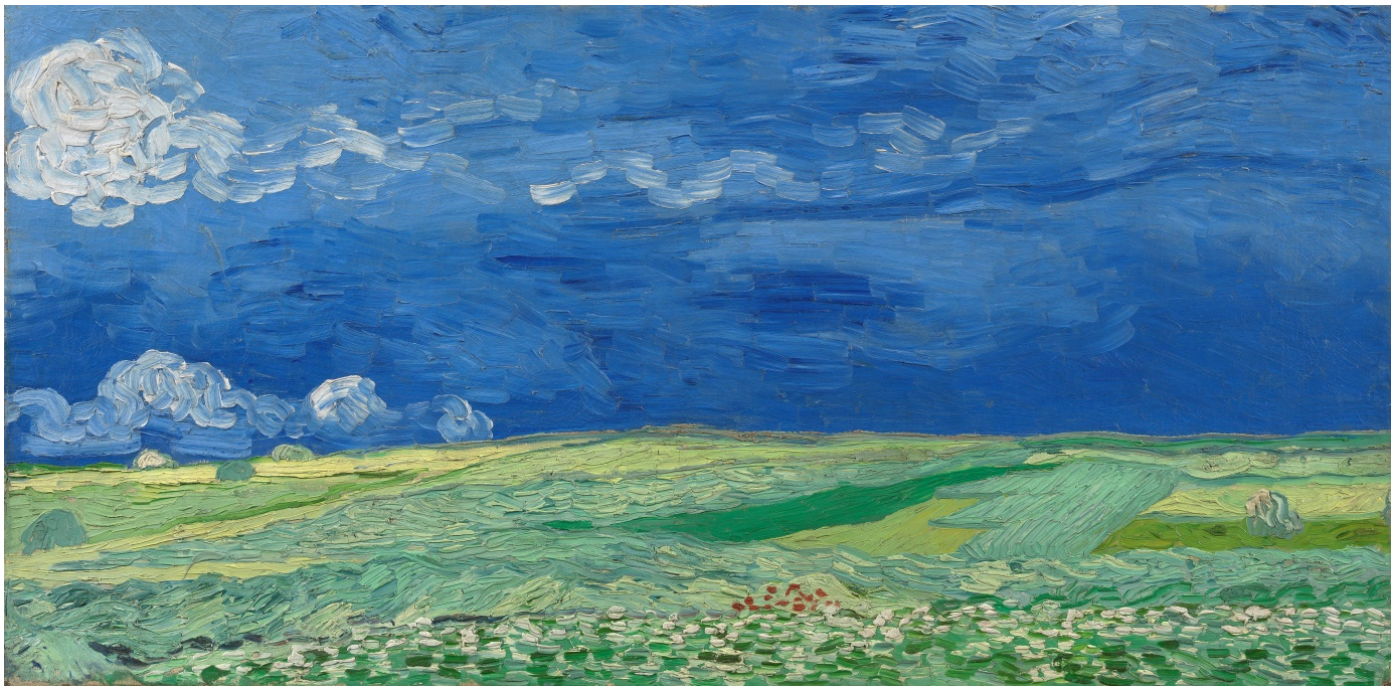
Figure 16: Vincent Van Gogh, *The Starry Night*, 1889, oil on canvas, 73.7 × 92.1cm.[279]

Sadly, Van Gogh's tranquillity was short-lived: his 'delirious' periods returned, and increased in frequency and intensity. He grew scared of the alienists he had once compassionately immortalised in his work. The staff at the asylum removed his paints after Van Gogh attempted to eat them several times; he was seized by 'paralyzing fear and hallucinatory fevers'.[280] Despite his worsening condition, Van Gogh left the asylum in May 1890 and, three months later, died from an apparently self-inflicted bullet wound to the stomach while out in the wheat fields surrounding the Ravoux Inn with his easel and brushes. One of the last paintings Van Gogh produced featured the wheatfields unfolding beneath

[279] Image taken from The Van Gogh Gallery, 'Catalog of Work' <http://www.vangoghgallery.com/catalog/> [accessed 4 February 2015].
[280] Naifeh, *Van Gogh*, p. 814.

gathering clouds, encapsulating both the immense serenity and latent power of nature and what Van Gogh 'consider[ed] healthy and fortifying about the countryside'.[281]

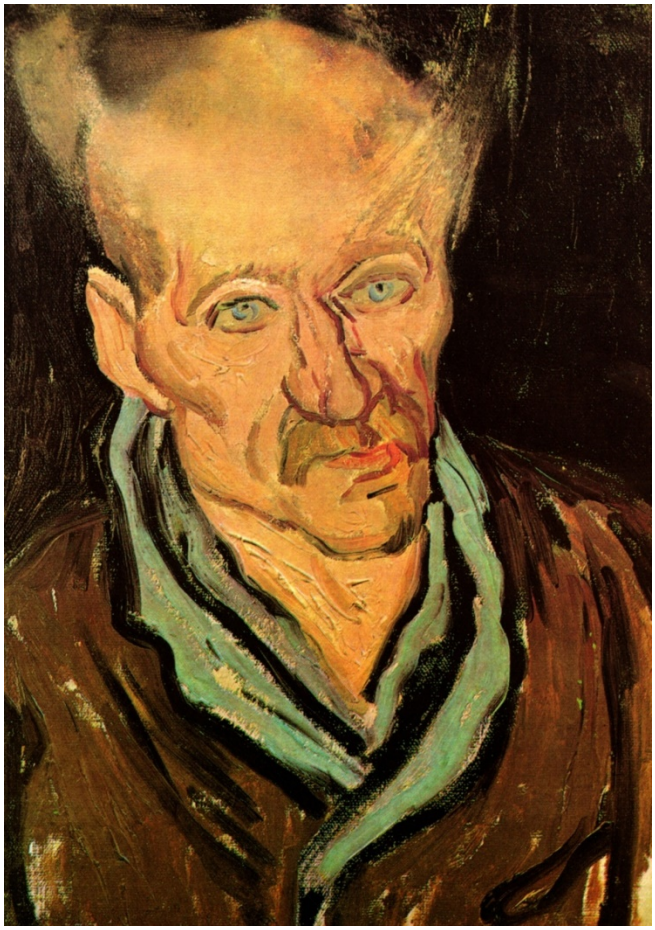
Figure 17: Vincent Van Gogh, *Wheatfield Under Thunderclouds*, 1889, oil on canvas, 72 × 92cm.[282]



Throughout his later work (anything produced in 1889-90), there is a subtle change in Van Gogh's style. The detail evident in the likes of *The Potato Eaters* (1885) or *The Harvest* (1888) gives way to fluidity. Realism has not been entirely jeopardised, but there is a *different*, unique kind of imitation: something more sensual and impressionistic. The sense of movement in *Wheatfield Under Thunderclouds* has been constructed using bold strips of colour: it looks as if it has been finger-painted, suggestive of use of a palette knife rather than brush. There is texture and movement. Van Gogh's iconic impasto technique has taken on another dimension. This almost abstract, sweeping style characterises the final phase of Van Gogh's artistic progression.

[281] Van Gogh, quoted in The Van Gogh Museum, 'Wheatfield Under Thunderclouds' <http://www.vangoghmuseum.nl/en/collection/s0106V1962> [accessed 5 February 2015].
[282] Image taken from Van Gogh Museum, 'Wheatfield'.

Figure 18: Vincent Van Gogh, *Head of a Patient*, 1889, oil on canvas, 32.5 × 23.5cm.[283]



The motif of asylum life was incorporated into Van Gogh's later works. Figure 18 is a portrait of a 'patient', produced during Van Gogh's year at Saint-Paul De Mausole. Although Van Gogh takes an *external* stance here – he is the observer, rather than the observed – this image still functions as part of his oeuvre which documents his experience in a psychiatric context. It represents 'madness' as something familiar: significantly the *mise-en-scène* and general execution are almost identical to Van Gogh's paintings of the asylum attendants and doctors. It is only the title which identifies one figure as a 'patient' and another as an 'attendant' or 'doctor'.[284] It also embodies the slight shift in style evident during this period. Van Gogh had previously referred to the impact bromide had on his concentration: 'not all

[283] Image scanned from the cover of Gilman, *Seeing the Insane*.
[284] See *Portrait of Trabuc, an Attendant at Saint-Paul Hospital* (1889) and *Portrait of Doctor Gachet* (1890). In light of Naifeh and White Smith's claim that 'for Vincent, no image was complete without a bold or suggestive caption […] he soundly rejected works that defied this narrative imperative', it is safe to assume that Van Gogh consistently titled his own work. See Naifeh, *Van Gogh*, p. 286.

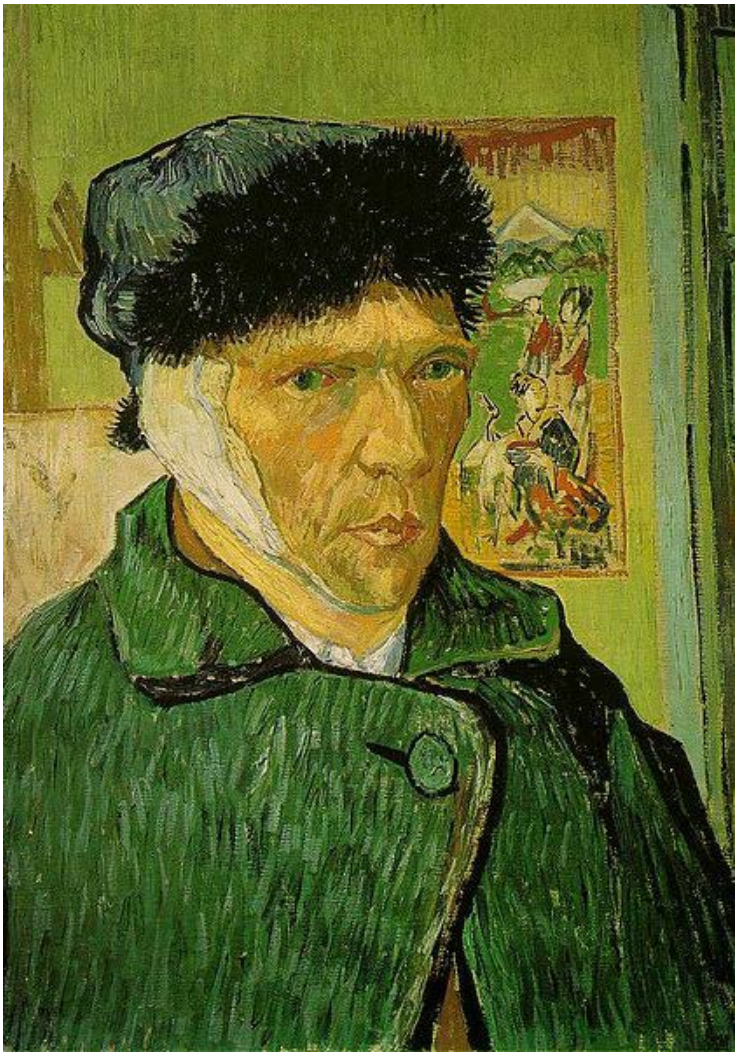
my days are clear enough for me to write logically'.[285] This may suggest that the bromide dispensed as part of Van Gogh's treatment was responsible for this increasingly abstract execution, allowing us to accept these later paintings as a visual account of Van Gogh's experiences at the hands of his psychiatrists.

Another characteristic of Van Gogh's work was his inclusion of the self as an artistic subject: he produced over 30 self-portraits during the last four years of his life, including two which feature the absence of his ear following his notorious act of self-mutilation. As with Wain's cat motif, the constancy (or, indeed, mutability) of the self as a subject allows for a direct comparison of this change in style. Figures 19 and 20 show the different ways Van Gogh negotiated the representation of the self between 1886 and 1889.

Figure 19: Vincent Van Gogh, *Self-Portrait with Dark Felt Hat*, 1886, oil on canvas, 41.5 × 32.5cm.[286]

[285] Naifeh, *Van Gogh*, p. 739.
[286]Image taken from The Vincent Van Gogh Gallery, 'Self-Portraits' <http://www.vggallery.com/painting/p_0208a.htm> [accessed 16 June 2016].

Figure 20: Vincent Van Gogh, *Self-Portrait with Bandaged Ear*, 1889, oil on canvas, 60 × 49cm.[287]



Academic Daniel Schneider argued that the self-portraits 'are constantly changing far beyond reality', and the change in execution can be read as representative of Van Gogh's 'madness' as it signifies a progressive escape from 'reality', much like Louis Wain's cats.[288] Van Gogh's penchant for self-portraits can also be interpreted as a way of holding on to or reconstructing the self when selfhood is jeopardised during a period of turmoil and trauma, such as illness. They chronicle change: both the external (ageing; changes in environment; physical alterations, most obviously the ear, or lack thereof) and the internal (signified by the change in style). In the midst of this chaos, the self is simultaneously constant – a consistent

[287] Image taken from Van Gogh Gallery, 'Catalog'.
[288] Daniel E. Schneider, 'The Psychic Victory of Talent (A Psychoanalytic Evaluation of Van Gogh)', *College Art Journal*, 3 (Spring, 1950), 325-37, (p. 328).

motif – and mutable, subject to the tides of time and perception. There is also a sense of self-exposure in these images. Van Gogh wanted the self to be revealed, rather than hidden behind the canvas (the kind of absence of self which would divorce Dadd's work from his biographical context).

Van Gogh, an admirer of writer Émile Zola, responded to Zola's desire to access the artist through art. Zola stated: 'I am for human truth […] I want artists to make life […] according to their own eyes and temperament. What I seek before everything else in a picture is a man and not a picture'.[289] When embarking on his career as an artist, Van Gogh reflected that 'I pay as much attention to the man who does the work as to the work itself', echoing Zola's sentiments.[290] Van Gogh's interest in the art as a product of the artist – rather than believing that art should be divorced from the context of its creation – impacted on the art/artist relationship portrayed in his own work. His desire to see the artist in the art meant that his art inevitably represented and revealed *his* self, therefore Van Gogh's work merged the art with the artist. For Van Gogh, the art must always reflect the self: unlike Roland Barthes's author, the artist *cannot* be dead. This is particularly significant when we consider Figure 20. Van Gogh's decision to include his bandaged ear reflects Zola's quest for 'human truth'. Although Van Gogh could have easily omitted the bandage (he was, after all, the one with artistic licence) or hidden it by painting the self from another angle, he does not: the bandage, denoting the absence of his ear, immediately arrests the eye of the viewer due to its central placement. The maimed self is laid bare: Van Gogh did not shy away from this self-exposure, and went on to paint an additional self-portrait which features the bandaged ear as the focal point.[291] The bandaged ear represents 'otherness': the potential for behaviour which

[289] Émile Zola, *Mes Baines*, quoted in Philip Callow, *Lost Earth: The Life of Cézanne* (Chicago: Ivan R. Dee, 1995), pp. 115-16.
[290] Naifeh, *Van Gogh*, p. 6.
[291] See *Self-Portrait with Bandaged Ear and Pipe* (1889).

is ‘a product of mental disorder and anguish’.[292] Van Gogh’s incorporation of the motifs of asylum life and the bandaged ear inevitably reflected on his experience of ‘madness’. Surely, it is not possible to read Van Gogh’s work as anything other than a ‘madness’ narrative?

In the case of Dadd, there was an evident fracture between aesthetics and biographical details – between the art and the artist – in order to justify and, to an extent, protect his artistic reputation and academic and societal interest in his work. However, as Van Gogh’s work is fundamentally rooted in the integration of the artist and the art, no such separation is viable. On the surface, as it is impossible to divorce Van Gogh’s ‘madness’ from his art, and because Van Gogh’s reputation as a mainstream artist is indisputable, we finally have an oxymoronic ‘mad’ artist. He is both socially accepted and socially ‘other’. Does the work of Van Gogh finally lend credibility to the use of art as a platform for a socially heeded ‘madness’ narrative?

This creates a complex social paradox: how can Van Gogh’s ‘madness’ be commended as visionary art, when ‘madness’ has, historically, been silenced? The morbid details of Van Gogh’s life have been widely circulated, distorted and trivialised.[293] Throughout the extensive and varied interest in Van Gogh’s life there is a common trend which seeks to minimise or justify his ‘madness’. These accounts take Van Gogh’s behaviour out of the realm of ‘madness’ and into the sphere of ‘eccentricity’: a prerequisite for the artistic temperament, a variant on ‘normal’ behaviour but not its polar opposite. Thus the two significant events which signify ‘madness’ – his episode of self-harm, and his suicide – have been socially rewritten in an attempt to read Van Gogh’s experiences as something other than symptomatic of ‘madness’.

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[292] Armando R. Favazza, *Bodies Under Siege: Self-Mutilation, Nonsuicidal Self-Injury, and Body Modification in Culture and Psychiatry* (Baltimore: John Hopkins University Press, 1996), p. *xix*.

[293] While in primary school, I vividly remember Van Gogh’s act of self-injury being justified as a romantic gesture: that he had removed his ear and given it as a gift to a lover, justifying it as an act of eccentricity, and thus deemphasising his ‘madness’.

Much like Dadd's contemporaries, who sought to justify his violent and erratic behaviour as a symptom of sunstroke, numerous physical ailments have been superimposed onto Van Gogh in an attempt to explain his actions. It has been speculated that tinnitus may be responsible for Van Gogh's self-mutilation: 'his tinnitus had become intolerable and that he felt he might alleviate the "auditory hallucinations" by eliminating their source'.[294] This places Van Gogh's ailment in the terrain of the physiological rather than the realm of the mind, portraying him as physically ill rather than 'mad'. Further conjecture offers a range of possible infirmities, from lead poisoning to syphilis. Society – despite the change and 'progress' that has occurred since the nineteenth century – seems consistently unable to accept Van Gogh's psychiatric diagnosis. The dominant cultural belief that 'madness' is a closed text has endured. By virtue of celebrating and circulating his art, to accept Van Gogh's 'mad' identity would necessitate an acceptance of the 'other'.

Recently, German art historians, Hans Kaufmann and Rita Wildegans, put forward an alternative explanation for the self-mutilation. Their hypothesis is that it was 'painter Paul Gauguin who actually lopped [… the ear] off with a sword during an argument', thus presenting Van Gogh as the victim of violence, rather than the problematic dual role of perpetrator/victim signified by self-harm.[295] This theory responded to the ambiguity of Van Gogh's act of self-injury and opened it up to be rewritten: the 'curator [of the Van Gogh Museum] Leo Jansen said "plenty of questions remain unanswered"', allowing for new interpretations.[296] The extremity of the act also supported this sense of ambiguity: as 'clinical cases of ear mutilation are quite rare', there is further scope to entertain alternative

[294] Megan Rosenfeld, 'Van Gogh's Madness: The Diagnosis Debate Lives On', *Washington Post*, 22 November 1998 <http://www.washingtonpost.com/wpsrv/style/museums/features/98vangogh/madgogh1122.htm> [accessed 8 February 2015].
[295] Henry Samuel, 'Van Gogh's Ear "Was Cut Off By Friend Gauguin With a Sword"', *The Telegraph*, 4 May 2009 <http://www.telegraph.co.uk/culture/art/art-news/5274073/Van-Goghs-ear-was-cut-off-by-friend-Gauguin-with-a-sword.html> [accessed 7 February 2015].
[296] 'Van Gogh Did Not Kill Himself, Authors Claim', *BBC News*, 17 October 2011 <http://www.bbc.co.uk/news/entertainment-arts-15328583> [accessed 8 February 2015].

theories.[297] Although coverage of the event in 1888 described Van Gogh's act of self-harm as one 'which could only be that of a pitiful madman', twenty-first-century discourses seem determined to obscure the assumption that this act was the result of 'madness'.[298]

For those who find no substance in the claims of tinnitus or who are unconvinced by the image of Gauguin wielding a sword outside a brothel, there has been a parallel academic trend which attempts to romanticise or eulogise Van Gogh's self-mutilation. At its extreme, French writer and philosopher Georges Bataille literally mythologised Van Gogh:

> There is, in fact, no reason to separate Van Gogh's ear […] from Prometheus's famous liver […] All the wealth he derives from the mythical delirium is limited to the incredible vomiting of the liver, ceaselessly devoured and ceaselessly vomited.[299]

Like Prometheus, a Greek mythological figure who gifted humankind with fire (and who then paid a hideous, visceral price), Van Gogh is presented as a conduit between something godly, a knowledge above and beyond human knowledge, and humankind. Prometheus gave us fire; Van Gogh gifted us his art, his visions. As punishment, Prometheus was chained to a rock in the Caucasus, daily subjected to the agony of an eagle eating his liver, which then regrew, only to be devoured once more. Bataille believed that Van Gogh's act of self-harm is akin to this martyrdom: the price of 'mythical delirium' and knowledge is eternal suffering. The theme of sacrifice runs through numerous accounts of Van Gogh's life and art: academic Eric Michaud observed that 'all Van Gogh's "madness" is connected to this extreme and painful knowledge that his very existence as a painter requires not only separation from others, but also the sacrifice of others, and above all of those closest to himself'.[300] Van Gogh's behaviour has been reconstructed as a form of martyrdom: suffering necessitated by his genius. Thus, his self-harm and eventual suicide can be read as an authentication of his

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[297] Favazza *Bodies Under* Siege, p. 119.
[298] *Le Forum Republicain*, 30 December 1888 <https://www.khanacademy.org/humanities/becoming-modern/avant-garde-france/post-impressionism/a/van-gogh-self-portrait-with-bandaged-ear> [accessed 13 February 2016].
[299] Georges Bataille, 'Sacrificial Mutilation and the Severed Ear of Vincent Van Gogh', in *Visions of Excess: Selected Writings 1927-1939*, ed. by Allan Stoekl (Woking: Unwin Brothers, 1985), pp. 61-72 (p. 70).
[300] Eric Michaud, 'Van Gogh, or The Insufficiency of Sacrifice', *October*, 49 (Summer, 1989), 25-39 (p. 33).

identity as an artist rather than threatening to undermine his art by declaring it a by-product of 'madness'. His oeuvre and his experiences have become 'the substance of myth' rather than a narrative of 'madness'.[301]

On a more literal level, it has been suggested that the removal of the ear echoes Biblical and literary motifs. This discourse integrates Van Gogh further into the realm of the symbolic, the metaphoric, and the martyred: a far cry from social 'perceptions of self-mutilation as grotesque […] cowardly […] pitiful [and] senseless'.[302] Gayford drew a comparison between Van Gogh's self-mutilation and a Biblical parable:

> In the New Testament, after Christ had accepted his fate, Judas burst into the garden accompanied by armed men, come to arrest him. When the disciples saw what was going to happen, they thought of defending Christ with force, 'And one of them smote the servant of the high priest, and cut off his right ear'.[303]

Having entertained ambitions of being a pastor and working briefly as a missionary, Van Gogh was undoubtedly familiar with this passage, thus potentially lending a new significance to his act of self-harm. It has also been suggested that this is 'a scene that van [*sic*] Gogh had tried to paint the previous summer', perhaps leading him to decide that, in this instance, his body was the most suitable canvas.[304]

Zola's novel, *Abbé Mouret's Transgression*, written in 1875, also contains a shocking scene of ear mutilation in which Brother Archangias is injured as penance for betraying protagonists Albine and Mouret: '[Albine's grandfather, Jeanbernat] calmly drew the knife from his pocket, opened it, and with a single cut sliced off the Brother's right ear'.[305] As Van Gogh's letters reveal an intense admiration of Zola, it would be a safe assumption that he was familiar with this scene which, again, allows for the act of self-harm to be read as something

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[301] Eugene Victor Thaw, 'The Abstract Expressionist', *The Metropolitan Museum of Art Bulletin*, 44 (Winter, 1986-1987), 8-56 (p. 45).
[302] Favazza, *Bodies Under* Siege, p. 3.
[303] Martin Gayford, *The Yellow House: Van Gogh, Gauguin, and Nine Turbulent Weeks in Provence* (New York: Little Brown, 2008), p. 279.
[304] Rosenfeld, 'Van Gogh's Madness'.
[305] Émile Zola, *Abbé Mouret's Transgression*, trans. by Ernest Alfred Vizetelly (New York: Mondial, 2005), p. 287.

symbolic, rather than an impulsive act of despair. A Freudian reading has also been offered, as 'one school points out the similarity between the Dutch words for ear (lel) and penis (lul), suggesting the act was a symbolic castration', of particular significance in light of Van Gogh's decision to deliver his dismembered ear to the local brothel.[306]

Similar academic trends have sought to rewrite Van Gogh's final days, claiming that, rather than taking his own life, he was actually murdered.[307] This reconstructed narrative 'resolves many of the contradictions, fills many of the gaps, and fits together many of the misshapen pieces of the traditional narrative of suicide that has dominated Van Gogh mythology since the day of the shooting'.[308] Divorced from the stigma of suicide, Van Gogh can be represented as a tragic figure, or victim. As Foucault observed, Van Gogh's 'work and his madness were incompatible', and so it became necessary for his 'madness' narrative to be sacrificed in favour of one which was more palatable.[309]

These alternative narratives reveal an urgent societal anxiety to displace Van Gogh's 'madness' and offer romantic, symbolic and mythological theories in its place. It is telling that Kaufmann and Wildegans spent ten years intensely researching Van Gogh's act of self-mutilation in an attempt to debunk it, and that *Van Gogh: The Life* (complete with its theory of murder rather than suicide) was the result of 'a 10-year venture, involving teams of researchers and translators'.[310] These theories respond to a *need*: a desire to find other explanations for the behaviour of 'one of the most famous painters in the world'.[311] This social trend to deemphasise Van Gogh's 'madness' is a direct result of his accessibility and

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[306] Rosenfeld, 'Van Gogh's Madness'.
[307] This claim is the result of extensive and impressive research conducted by Steven Naifeh and Gregory White Smith, although rumours and speculation predate their publication. For the details of this alternative narrative, see Naifeh, *Van Gogh*, pp. 867- 85.
[308] Naifeh, *Van Gogh*, p. 873.
[309] Foucault, *Civilization*, p. 273.
[310] William Feaver, 'Van Gogh: The Life by Steven Naifeh and Gregory White Smith – Review', *Guardian*, 21 December 2011 <http://www.theguardian.com/artanddesign/2011/dec/21/van-gogh-the-life-review> [accessed 8 February 2015].
[311] The Van Gogh Gallery, 'Vincent Van Gogh Paintings' <http://www.vangoghgallery.com/painting/> [accessed 8 February 2015].

credibility as an artist: because his work is admired and celebrated, it cannot be read as a 'madness' narrative, lest we find ourselves not only receiving a 'madness' narrative, but also relating to it and, ultimately finding *truth* or *meaning* in it. Although Van Gogh's work directly addressed his experience of 'madness', incorporating the motif of the bandaged ear, and featuring images constructed in, and reflecting on, the asylum space, there is an enduring societal reluctance for his art to be accepted on such terms.

'The Madness Which Interrupts It': The Paradoxical 'Mad' Artist[312]

Although, in theory, art allows for 'complete and unhindered communication', the social reception of art, necessary for this communication to be heard, proves that the practice is far removed from this romantic hypothesis.[313] The idea of 'mad' art is, in itself, an oxymoron: in the realm of social engagement, either artistic credibility is compromised and eventually disparaged, or 'madness' is deemphasised and, ultimately, silenced.

For Wieser, Klett and Wain, the psychiatric context ensured that their 'madness' was paramount. On the one hand, their art is undoubtedly perceived as a 'madness' narrative: it is a creation which directly addresses their alternative experiences of 'reality'. On the other hand, because of this, their work is deemed symptomatic of their 'madness'. Rather than being a space in which these experiences are articulated, these narratives become representative of the inevitable 'otherness' which is enforced by their contact with psychiatry. Because their 'madness' is paramount, the artistic value of these pieces is jeopardised: the process is reduced to 'image-making', rather than art, and thus not deemed worthy of the viewer's attention. This art is limited to a rhetoric which reflects 'otherness', nothing more. The viewer may *witness* 'madness' on such a canvas, but not *empathise* because of this

[312] Foucault, *Civilization*, p. 273.
[313] Dewey, *Art as Experience*, p. 109.

pervasive sense of 'otherness' which has been attached to it: 'the experience of *the other* is not evident to me, as it is not and never can be an experience of mine'.[314]

Dadd's and Van Gogh's work has found a place in the canon of mainstream art. However, because of their reputation as artists, their 'madness' narratives have been eclipsed in favour of the superficial and the aesthetic. With Dadd, there has been an overt rejection of biographical detail. Van Gogh's behaviour has been romanticised and mythologised in order for it to be viewed as a by-product of his artistic temperament, rather than his 'madness'. Mainstream society has divorced this art from its 'mad' genesis in order to justify its reputation *as* art.

Wölfli occupies a liminal space in this 'mad'/'artist' binary. Reclaimed by the Outsider Art genre, his work has been granted the limited status of 'othered' art. Although this platform has allowed Wölfli's narrative to be seen as both art and an articulation of 'madness', the work's context necessitated an acceptance of the position of 'outsider'. Because of this, Wölfli's art cannot be divorced from its 'otherness', and therefore it will always be couched in the psychiatric conception of 'mad' as 'other'. If anything, it reinforces hegemony, exhibiting the inherent and irrevocable difference of the 'madman'.

It is also worth reconsidering context. The artists I have covered all have the privilege of voice to some degree: albeit tremendously limited, and often distorted or disregarded. But what about everyone else? Maclagan reflected that 'most psychotic patients did not make anything that could conceivably be called "art": of those that did (less than 2 per cent, according to Prinzhorn) only a tiny minority produced anything of real artistic interest'.[315] Those covered in the scope of this chapter are, presumably, in that tiny minority. That two per cent have the dubious privilege of having their work exhibited long enough for a psychiatric or mainstream audience to consider (and eventually disregard) its merits as pieces

[314] Laing, *Politics*, p. 16. Emphasis in original.
[315] Maclagan, *Outsider Art*, p. 93.

of art. But what about the ninety-eight percent, those whose work is immediately considered *non*-art? Although Tolstoy suggested that the main activity of art was empathy, the status of 'artist' seems tremendously divisive and evasive. The fact that 'madness' 'interrupts' art – rather than being a phenomenon which can be contained and communicated in art – suggests that the status of 'mad' artist is entirely unachievable: a romantic myth with no applicability to those who *need* it.[316]

For the individuals addressed in this chapter, art offered a haven and a creative outlet. It was a way of untangling the chaos of life in a psychiatric context; a method of documenting the self in the face of tumultuous change; and, for some, it was a space in which psychiatric 'authority' could be subtly challenged.[317] It was a niche in which the self could be 'restored from the disfigurements of language', however temporarily. [318] In a societal context, we are stuck in the psychiatric tradition of disregarding the individual narrative in favour of hegemonic discourse. We do not acknowledge these narratives because they are 'other': rather than heeding and embracing this difference, we ostracise it. Until our approach to 'madness' narratives changes, silence will endure, regardless of the forms these narratives take.

[316] Foucault, *Civilization*, p. 273.
[317] In a psychiatric culture which has determined lack of insight as further evidence of 'madness', the 'mad' self cannot *overtly* challenge hegemonic discourse, a premise which is echoed in Laing's *Knots: '*They are playing a game. They are playing at not playing a game. If I show them they are, I shall break the rules and they will punish me. I must play their game, of not seeing I see the game'. See Laing, *Knots*, p. 1.
[318] Berthold, 'Talking Cures', p. 300.

CHAPTER FIVE

The Psychiatric, The Political and The Personal: How We Talk about 'Madness' Today

My primary focus on nineteenth-century culture (from psychiatric texts to a variety of 'madness' narratives) has shown how hegemonic discourse of 'madness' has been established and, more importantly, the impact that it has had on the narration of the individual experience. However, this thesis is not intended as simply an historical investigation: this chapter will demonstrate that the nineteenth-century model for talking about and representing 'madness' remains firmly entrenched in Western culture. It is still both the foundation for the psychiatric conceptualisation of 'madness', and the frame through which 'madness' is viewed in a social context. Despite recent academic and activist trends to identify and eradicate stigma, the semantic framework available for diagnosing and discussing 'madness' is still intertwined with the nineteenth-century asylum 'us' versus 'them' culture.[1] The language of hegemonic discourse will always be an implement of oppression rather than liberation: as writer and activist Audre Lorde argued, 'the master's tools will never dismantle the master's house'.[2] The master's tool – the loaded, psychiatric language *about* 'madness' – cannot be used to disassemble the master's house or, in this case, the spectre of the asylum that hovers at the margins and that 'others' any mainstream representation of 'madness'.

By way of introduction, I will revisit and summarise the primary semantic tropes which collectively shape the way 'madness' is perceived and (mis)understood. These will be established by two quotations, removed from any indicators of context: one will be from the

[1] Social and academic discourses which attempt to challenge mental health stigma include the Time to Change and Rethink Mental Illness campaigns, and the rise of 'Mad Studies'.
[2] Audre Lorde, quoted in P. J. McGann, 'On the Transformation of Theory into Poetry and Praxis', in *Cultural Activisms*, ed. by Gertrude M. James Gonzalez and Anne J. M. Mamary (Albany: University of New York Press, 1999), p. 351-62 (p. 356).

genesis of psychiatric and asylum culture (from the nineteenth or early twentieth century); the other will be part of Western twenty-first-century discourse.[3] Disconcertingly, these quotations feature in psychiatric textbooks: they are being used to shape a new generation using this archaic, inadequate and damaging semantic framework of talking *about* 'madness' but not *of* it.

Next, I investigate narratives taken from popular culture, in order to see the influence of psychiatric discourse in shaping social dialogues about 'madness'. Episodes of *The Simpsons*; *House*; and *Peep Show* have been chosen for their universal appeal and wide audience: they function as sources of information, both as a product, and a reinforcement, of mainstream cultural discourses. What (mis)information about 'madness' is disseminated and reinforced through these shows? How has this, in turn, (mis)informed mainstream society about what 'madness' is, and how psychiatry manages 'madness'? How have such representations monopolised the dialogue about 'madness', which continues to isolate lived experience from a potential audience?

This chapter also examines other mainstream twenty-first-century sources of (mis)information in order to investigate the impact that both psychiatric narratives and such fictionalised accounts have had on the collective social consciousness. By exploring the language employed by the media and other sources (such as the 2013 controversy over supermarkets Asda and Tesco's 'mental' Hallowe'en costumes), I establish what popular discourses about 'madness' reveal about entrenched societal prejudices. Primarily, I focus on the concept of institutionalisation – a continuous theme, despite the deinstitutionalisation championed in the 1980s in the UK by the 'care in the community' policy. I establish how this is demonstrative both of the continued reliance on nineteenth-century discourses of

[3] Although these quotations have been edited slightly to remove any indicators of context (such as archaic terms), I have endeavoured to leave them as close to their original wording as possible. Any alterations have been recorded in parentheses.

'madness', and also of a deep-seated social anxiety about the 'mad' individual who is not policed or contained by psychiatric forces.

Despite our pretences to civility, of scientific and medical progress, despite our heightened awareness of stigma and our efforts to demarginalise the 'other', little has changed. We know we must dismantle the master's house (or, indeed, the metaphorical asylum), and yet we are still reliant on the master's tools. Until we find *new* tools – new ways of understanding and discussing 'madness' – we will never entirely be able to deconstruct the stigma and disenfranchisement at the centre of hegemonic discourse. Once this chapter has established how we talk about 'madness', I will ascertain what needs to change in order for lived experience of 'madness' to be at the heart of this discourse, rather than the passive object of psychiatric and societal conversation.

Trope One: 'Madness' Narratives are Incoherent, 'Closed' Texts[4]

'Speech is difficult to interpret […and there is a] loss of associations between words, [so] speech is experienced as an incoherent jumble'

'Incoherence of the train of thought […] is usually distinctly noticeable […and] the most different ideas follow one another'

These quotations clearly establish 'madness' as a deviation from the abstract concept of 'normality'. Both quotations feature the term 'incoherent' or 'incoherence', and both identify a lack of connections – apparent signifiers of 'normal' speech – between words. The term 'incomprehensible' features prominently in psychiatric accounts of mental illness, particularly 'schizophrenia': allegedly, its 'very essence is "incomprehensibility" itself'.[5] Use of this term, 'incomprehensibility', is a tactic used to implement 'otherness', to enforce distance between 'us' and 'them'. In the context of the nineteenth century, this

[4] I have deliberately withheld reference details for the two quotations at the beginning of each 'trope' section, as revealing this information would defeat the object. At the end of the appropriate section, full referencing details are given.
[5] Sass, 'Introspection', p. 4.

marginalisation was taken to a literal level: the asylum space signified a removal from the social sphere. However, in our twenty-first-century context, where initiatives claim to champion individual-led treatment, it seems paradoxical that the trope of 'incomprehensibility' is still a prominent feature in psychiatric discourse.[6] How can an individual be both central, and peripheral, to psychiatric conversations about their 'illness' and 'treatment'? Despite our cultural concerns about stigma and discrimination, psychiatric language – the active entity in shaping medical and societal attitudes – still signifies 'ways of not understanding' 'madness'.[7]

This assumption that 'madness' is 'incomprehensible' is a self-defence mechanism employed by hegemonic discourse: a manoeuvre which declares any potential counter-narrative a 'closed' text, unworthy of interpretation. It constructs 'madness' in terms of perceived absence: a lack of comprehensibility. Rather than finding ways to accommodate or respond to such narratives, they are discarded. These texts do not conform to hegemony, therefore they are beyond orthodox understandings of 'madness'. Such semantic choices are the 'quickest and most efficient way of implying lack of intelligibility and suggesting a pathological or deficient individual', of demarcating and silencing the 'other'.[8]

The first quotation, 'speech is difficult to interpret […and there is a] loss of associations between words, [so] speech is experienced as an incoherent jumble', is taken from a list of 'psychopathology: disorders of speech', found in a twenty-first-century textbook: Neel Burton's *Psychiatry*, the second edition of which was published in 2010.[9] By contrast, the second quotation, 'incoherence of the train of thought […] is usually distinctly noticeable in the conversations […and] the most different ideas follow one another', featured

[6] For example, the 2013/14 'Putting Patients First Initiative' (despite the obviously problematic label of 'patient') and the recent trend for 'personalisation' in mental health care.
[7] Laing, *Divided*, p. 33.
[8] Mary Boyle, 'Making the World Go Away, and How Psychology and Psychiatry Benefit', in *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition*, ed. by Mark Rapley, Joanna Moncrieff and Jacqui Dillon (London: Palgrave Macmillan, 2011), pp. 27-43 (p. 41).
[9] Neel Burton, *Psychiatry*, 2nd edn (Chichester: Wiley Blackwell, 2010), p. 19.

in Kraepelin's *Dementia Praecox and Paraphrenia*, published in 1916.[10] There are nearly one hundred years between both texts, and yet they rely on the same hypothesis – that a 'madness' narrative is 'incomprehensible' and unworthy of interpretation. They echo each other's sentiments and semantics: rather than representing progress, a comparison of these quotations instead demonstrates just how little has changed.

Trope Two: The 'Mad', Unreliable Narrator

'An 18-year-old man suffering from hallucinations and delusions […] is unable to give any meaningful history'

'I begin the treatment […] by asking the patient to give me the whole story of his life and illness […] as a matter of fact the patients are incapable of giving such reports about themselves'

Even if 'madness' narratives were accessed in spite of their alleged 'incomprehensibility', the individual experiencing 'madness' has been declared an unreliable narrator by psychiatric discourse. Any 'claims to speak authoritatively about their experiences are undermined by the predominant public perception of them [the individual experiencing "madness"] as "unreliable" witnesses, subject to hallucinations, delusions and violent tendencies'.[11] Psychiatry is the 'authority': 'madness' has no place to speak of its own history or, indeed, its present. This devaluation of lived experience of 'madness' is yet another manoeuvre designed to reinforce the power of psychiatric hegemony at the expense of the individual's right to speak and be heard. This hypothesis takes 'madness' out of the realm of individual experience, and into the domain of the medical and clinical. In this dynamic, the individual is 'required to be passive, such that medicine can act […] to correct the abnormality': personal

[10] Kraepelin, *Dementia Praecox*, p. 56.
[11] Cross, *Mediating Madness*, p. 33.

narratives, which contextualise 'madness' in a frame of life experience, are overridden by hegemonic discourse which requires only that the self surrenders to its 'authority'.[12]

By establishing and reinforcing the idea that the 'mad' individual is unable to offer any insight into, or knowledge of, their ailment or their history, the 'authority' of hegemonic discourse is further reinforced. Psychiatric knowledge dominates: despite living with and through an experience of 'madness', the individual has no authority. Thus psychiatric narratives move further and further away from personal experience: rather than working in harmony, there has been an inevitable and seemingly irrevocable fracture. Psychiatric discourse prevails, shaping societal perceptions of what 'madness' is: it reflects and reinforces its own assumptions and myths, and the individual narrative has been excluded from this rhetoric.

The first passage – 'an 18-year-old man suffering from hallucinations and delusions […] is unable to give any meaningful history' – has been taken from a psychiatric textbook published in 2000.[13] The subsequent quotation – 'I begin the treatment, indeed, by asking the patient to give me the whole story of his life and illness […] as a matter of fact the patients are incapable of giving such reports about themselves' – formed part of Freud's early twentieth-century reflections on the case studies of Dora and Little Hans.[14] This pattern of disenfranchising the individual persists and is still a prominent feature in mainstream (mis)understandings of 'madness': despite the anti-psychiatric movement attempting to reinstate the power and knowledge of the 'mad' self, it appears that very little has changed during the century which separates these quotations.

Trope Three: 'Madness' and Visual Stereotypes

[12] Ewen Speed, 'Discourses of Acceptance and Resistance: Speaking Out About Psychiatry', in *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition*, ed. by Mark Rapley, Joanna Moncrieff and Jacqui Dillon (London: Palgrave Macmillan, 2011), pp. 123-40 (p. 126).
[13] Roderick Shaner, *Psychiatry*, 2nd edn (Maryland: Lippincott Williams and Wilkins, 2000), p. 6.
[14] Freud, *Case Histories I*, p. 46.

‘Anxiety […] mo[u]ld[s] their expression’

‘Mood states are accompanied by characteristic facial expressions and postures […] turning down of the corners of the mouth and vertical furrows in the brow suggest depression; whereas horizontal furrows on the brow […] suggest anxiety’

The nineteenth-century rise in phrenology sought to superimpose ‘madness’ onto the canvas of the body, evidently needing to ‘discern the outward marks of a mind’ on the physical self.[15] Phrenologists attempted to forge a connection between the ‘mad’ self and the ‘mad’ body: to read ‘the outer man [as] a graphic reproduction of the inner’.[16] As ‘enlightened’, twenty-first-century beings, we may collectively scoff at the archaic pseudoscience of phrenology and physiognomy, but the similarity between these two quotations suggests that we still rely on the foundation of these practices in our attempts to demarcate and represent the ‘mad’ body. As with the trope of the ‘mad’, unreliable narrator, the hypothesis that ‘madness’ can be discerned from the physical self is a way of (mis)understanding from a distance. Phrenology and physiognomy are practices which make the personal experience redundant: if the self can be read from the exterior, there is no need to consult or communicate with the ‘mad’ individual. Again, there is a firmly entrenched disconnect between hegemonic discourse and personal narrative.

The idea that ‘madness’ looks a certain way has resulted in the ‘madman’ ‘encompass[ing] a wide spectrum of visual stereotypes’.[17] Such phrenological ideas establish ‘madness’ as something which consumes the individual, reconstructing both their internal and external selves. Rather than being a transient state, ‘madness’ is deemed a destination from which the physical and psychological self does not return. It equates alternative mental states with visible difference, thus resulting in ‘madness’ being portrayed as an encompassing ‘otherness’. This is a trope which has endured throughout over one hundred years of psychiatry: despite our belief in progress, we still rely on this assumption that the ‘mad’ self

[15] Conolly, ‘Physiognomy’, p. 20.
[16] Gilman, *Seeing the Insane*, p. 164.
[17] Gilman, *Seeing the Insane*, p. 116.

can be read on the body. The first quotation, 'anxiety […] mo[u]ld[s] their expression', is taken from Lombroso's 1876 publication, *Criminal Man*.[18] The second quotation, 'mood states are accompanied by characteristic facial expressions and postures […] turning down of the corners of the mouth and vertical furrows in the brow suggest depression; whereas horizontal furrows on the brow […] suggest anxiety', featured in a psychiatric textbook from 2012.[19]

Trope Four: 'Madness' Requires Psychiatric Intervention/Management

'Dissimulation on the patient's part is, naturally, only a concealment of thoughts and symptoms […] for they themselves do not consider themselves sick'

'Insight is almost always impaired. Most patients do not accept that their experiences result from illness, but usually ascribe them to the malevolent actions of other people'

When I first starting working in mental health, I encountered the phrase 'lack of insight'. When asked, my colleague explained that this was a psychiatric term which was attached to individuals who challenged or did not fully 'comprehend' their 'illnesses'. Thus, if a 'mad' individual does not accept hegemonic discourse (in this case, their diagnosis), they are deemed to *have no insight* – an idea which I found particularly uncomfortable. The political ramifications of this concept of 'insight' have been explored by Anne Rogers and David Pilgrim: 'insight means that a patient agrees with their psychiatrist […] where agreement breaks down in a psychiatric encounter between doctor and patient, then the more powerful party has their view upheld'.[20] Why does psychiatry assume it understands the experience of the individual better than the person in question?

The concept of insight immediately recalled for me the Lacanian suggestion that 'madness' is perceived as 'a kind of non-knowledge': that the 'mad' individual, by virtue of

[18] Lombroso, *Criminal Man*, p. 214.
[19] John Geddes, Jonathan Price and Rebecca McKnight, *Psychiatry*, 4th edn (Oxford: Oxford University Press, 2012), p. 29.
[20] Anne Rogers and David Pilgrim, *A Sociology of Mental Health and Illness*, 4th edn (Berkshire: Open University Press, 2010), p. 171.

their alleged ‘unreason’, cannot comprehend or fully understand the self.[21] The assumption of an absence of insight suggests that ‘madness’ requires an external force – in this case, psychiatry – to manage it, to be the source of knowledge and of ‘authority’. Psychiatric intervention is apparently required because ‘madness’ cannot recognise its own ‘otherness’. Borne out of eighteenth- and nineteenth-century discourses which depict ‘madness’ as a state of ‘unreason’, this idea of insight appears, at best, archaic and conceited. How can the assumption that ‘madness’ is a deviation from the abstract concept of ‘reason’ be such a fundamental component in the medical (mis)understanding of the individual?[22]

As both of these quotations show, there is an enduring rhetoric which suggests ‘madness’ cannot even recognise, let alone manage, itself. Psychiatric intervention is necessary to take the ‘mad’ self from a state of non-knowledge to an acceptance of his or her own ‘madness’, and thus of hegemonic discourse. Echoing the other tropes, the idea that ‘madness’ *requires* psychiatric ‘authority’ disregards the individual experience which has no place in the medicalisation of the self.

The spectre of asylum culture is inescapable: the individual or even mainstream society (were it so inclined) cannot accommodate ‘madness’ because it is an experience which has been irrevocably pathologised and thus belongs exclusively to the psychiatric sphere. As I will discuss shortly, this rhetoric of institutionalisation is particularly problematic in the light of political changes, namely the ‘care in the community’ policy which promotes deinstitutionalisation. As James Davies observed, ‘as soon as you’re assigned a diagnosis […] you become a protagonist in a larger myth […] you have entered into a social contract in which you are now socially positioned as dependant on psychiatric

[21] Cutler, ‘Philosophical Coquetry’, p. 93.

[22] Let us consider this from another perspective. During a medical examination, if one were to complain of, say, nausea and food aversion, the doctor may suggest that the individual could be pregnant. If the individual disagrees with this perception, are they deemed as showing a ‘lack of insight’? Or is the ‘authority’ of the individual considered reliable enough information to discount that possibility? Why is personal experience judged to be reliable in one medical context, when, in the case of ‘madness’, it is not only marginalised but also regarded as non-knowledge?

authority'.[23] In the face of a mental health system which now gravitates towards 'care in the community' over exclusively psychiatric environments, does this render the 'mad' individual placeless, ungoverned – perhaps even *free*? This concept will be explored in more detail shortly. However, it is worth acknowledging that the assumption that 'madness' requires psychiatric management – the emblem of which is the nineteenth-century asylum – has led to a societal fear of 'madness' which escapes or eludes such 'authority'.

The first quotation – 'dissimulation on the patient's part is, naturally, only a concealment of thoughts and symptoms […] for they themselves do not consider themselves sick' – is taken from Bleuler's 1924 publication, *Textbook of Psychiatry*.[24] The subsequent passage – 'insight is almost always impaired. Most patients do not accept that their experiences result from illness, but usually ascribe them to the malevolent actions of other people' – featured in the *Shorter Textbook of Psychiatry*, published in 2012.[25] Despite being written eighty-eight years apart, the similarity between these extracts is uncanny: the primary message being that 'madness' *is* 'madness' because it does not *accept* its own 'madness'. It requires psychiatric governance.

Trope Five: 'Madness' and 'Otherness'

'Although it may not always seem so [detaining an individual against their will it] may, in fact, be a very caring thing to do: akin to lifting and holding a two-year-old having a tantrum'

'The patient behaves like a little child'

The representation of 'madness' as a state of 'otherness' – here, exhibited by infantilisation – may seem quite an obvious trope. All of the quotations I have looked at thus far demonstrate the various ways that this 'otherness' can be enforced, from undermining the reliability of the personal experience, to phrenological assumptions that 'madness' is both internally and

[23] Davies, *Cracked*, p. 219.
[24] Bleuler, *Textbook*, p. 192.
[25] Cowen, *Textbook of Psychiatry*, p. 257.

externally ‘other’. However, the above quotations explicitly portray the ‘mad’ individual as something ‘other’ than an autonomous adult, and depict psychiatry as a paternal force which must control the ‘mad’, unruly child. As with the assumption that ‘madness’ requires psychiatric intervention, this trope is a way of diminishing the power and autonomy of the individual. Evoking Lacanian power dynamics, ‘madness’ is depicted as ‘a failure to accept or even to recognise what [Lacan] calls *nom du père* […] the whole complex of rules, interdictions, concepts, and words that the child must accept’ to transition into the adult world.[26] Because ‘madness’ cannot conform to psychiatric discourse without being automatically ‘othered’, it will remain in a state of perpetual infantilisation and powerlessness.

Despite representing a break from the conventional psychiatric school of thought, even the anti-psychiatry movement portrayed ‘madness’ as a return to a child-like state. Barnes, during her stay at Kingsley Lodge, was instructed by Laing and Berke to ‘go down and come up again. Be as a child. Go mad. Regrow’.[27] However, anti-psychiatric discourses saw an experience of ‘madness’ as an opportunity to reconfigure the self: to return to infancy in order to regrow, relearn and reinstate the power and autonomy of the individual. By contrast, mainstream psychiatric discourse depicts ‘madness’ as a state of childish ignorance – again, the recurring trope of non-knowledge – which can only be rectified with an acceptance of and voluntary capitulation to the *nom du père*.

‘Although it may not always seem so [detaining an individual against their will] may, in fact, be a very caring thing to do: akin to lifting and holding a two-year-old having a tantrum’ is an extract from the *Oxford Handbook of Psychiatry*, published in 2013.[28] The

[26] Sass, ‘Ineffable’, p. 321.
[27] Barnes, *Mary Barnes*, p. 109.
[28] Semple, *Handbook*, p. 16.

assertion that ‘the patient behaves like a little child’ featured in Bleuler’s 1924 publication, *Textbook of Psychiatry*.[29]

Is ‘Madness’ ‘Incomprehensible’, or Are We Just Not Listening? What it All Means

The purpose of these comparisons is to debunk the assumption that psychiatry is an objective, absolute and developed practice. In reality, despite pretences of progression, psychiatric (mis)understandings of ‘madness’ are firmly rooted in archaic, outdated models of ostracising, alienating and ‘othering’ ‘madness’. It is easy (and undoubtedly comforting to our collective social consciousness) to presume that ‘madness’ is in safe hands; that a psychiatric intervention is both necessary and just. To question the assumption that psychiatry is infallible is simultaneously to challenge our reliance on psychiatric discourse. This would force us to face the possibility that we have been actively supporting a damaging and totalitarian discourse of disenfranchisement. Until we question what the institution of psychiatry tells us, we are complicit. Until we deconstruct assumptions that ‘madness’ is ‘incomprehensible’, ‘unreliable’, ‘other’, we are no better than our nineteenth-century counterparts. Our restraints may be chemical rather than mechanical, but we still control. We may section rather than incarcerate, but we still ostracise. We may be aware of stigma, but only as an abstract concept: *we still do not listen*.

The comparison of narratives from over one hundred years of psychiatric ‘progress’ demonstrates that, even though the setting may have changed, the language has not. Although nineteenth-century psychiatry could be regarded as having good intentions gone awry, as the result of medical or psychological ignorance, we, in the twenty-first century, have no such excuse. Philosopher and poet George Santayana mused that ‘those who cannot remember the past are condemned to repeat it’: those who do not learn from history’s mistakes will never

[29] Bleuler, *Textbook*, p. 165.

progress.[30] This chapter exposes just how stunted this development has been. By examining how 'madness' is talked about in our twenty-first-century context, I show how psychiatry's refusal to learn from its own legacy has established and reinforced the societal stigma which we appear to be so desperate to eradicate. I expose how mainstream discourses of 'madness' are entirely reliant on medicalised, psychiatric discourse and how our (often unknowing) acceptance of hegemonic narratives has resulted in us being complicit in silencing those we seek to include. Our quest to *comprehend* 'madness' by extensively documenting it with elaborate editions of the *DSM*; and our attempts to establish a dialogue by (mis)representing 'madness' in popular culture, have only further perpetuated the myth of its *incomprehensibility*.

Psychiatrist David Healy has argued that, when it comes to managing 'madness', 'we are becoming less rather than more rational'.[31] As I show, there is little to distinguish the nineteenth-century alienist from the twenty-first-century psychiatrist. The *DSM* has been described as 'a nineteenth-century construct'; a tool for a categorisation process that is distinctly Kraepelinian.[32] These attempts to explain the nosology and prognosis of 'madness' as a biological entity of disease (rather than a social phenomenon) have resulted in stagnation, rather than progress: 'there seems to be a lack of evidence to support the notions that explanatory paradigms used by psychiatry changed much over the course of a century'.[33]

Despite decades of somatic treatments, extensive scientific research and numerous editions of the *DSM*, mental illnesses continue to elude psychiatry. Most disconcertingly, the individual in the mental health system today has the same chance of 'recovery' as their nineteenth-century equivalent. In the nineteenth-century asylum, 'recovery rates of up to 50

[30] George Santayana, *The Life of Reason* (Auckland: Floating Press, 2009), p. 312.
[31] Healy, *Psychopharmacology*, p. 5.
[32] Edward Shorter, *What Psychiatry Left Out of the DSM-5: Historical Mental Disorders Today* (London: Routledge, 2015), p. 24.
[33] Rogers, *Sociology*, p. 156.

percent were reported. Such rates are comparable to those of psychiatric facilities today'.[34] Prior to the existence of community care, outpatient treatment, and medication, 'the only real treatment for severe mental illness was institutionalisation'.[35] A twenty-first-century 'service user' will likely encounter a dizzying array of powerful medication (and an equally dizzying range of side effects, some of which may severely impair quality of life)[36]; several diagnostic labels (which often vary from psychiatrist to psychiatrist)[37]; and a dubious 'scientific' theory to explain their suffering.[38] We have these 'tools' – questionable as they might be – and yet our recovery rates are no different from those boasted by nineteenth-century institutions, which were borne out of a desire simply to 'segregate the mad from society'; to ostracise 'madness', not to cure it.[39] Any 'recovery' was, indeed, incidental. This façade of 'progress' may have helped develop the reputation of psychiatry, but it has done little to address the primary issue at the centre of the mental health system: we are labelling, we are medicating, we are sectioning, administering electroshock therapy, using chemical restraints, and yet *we are still not helping*.

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[34] Healy, *Psychopharmacology*, p. 12.

[35] Jeffrey A. Lieberman with Ogi Ogas, *Shrinks: The Untold Story of Psychiatry* (London: Weidenfield and Nicolson, 2015), p. 153.

[36] For example, antipsychotic medication is associated with tardive dyskinesia (which I discuss shortly) and a decrease in number of white blood cells; antidepressant medication with increased suicidality; antianxiety medication with dependency and memory loss; and mood stabilisers with seizures and hallucinations (to name but a few adverse effects). Information taken from National Institute of Mental Health, 'Mental Health Medications' <http://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml> [accessed 17 June 2016].

[37] A 2007 study in *Psychiatry* journal reports that 86 per cent of psychiatrists asked felt that diagnostic reliability was poor. See Davies, *Cracked*, p. 18.

[38] The history of psychiatry is littered with examples of dubious science, including malarial treatments, insulin coma therapy and leucotomies. Disconcertingly, however, psychiatry's present – and the reality of being a 'patient' in the current mental health system – is also defined by questionable science. Consider, for example, the continued practice of electroconvulsive therapy, even though The Royal College of Psychiatrists are only able to give the following explanation: 'No-one is certain how ECT works'. See The Royal College of Psychiatrists, 'Information about ECT' <http://www.rcpsych.ac.uk/healthadvice/treatmentswellbeing/ect.aspx> [accessed 29 July 2015]. Further, the development of psychotropics, the cornerstone of 'care in the community', is a narrative of the theoretical rather than the empirical and of accidental discovery (not to mention a total disregard for 'patient' welfare and animal cruelty). For example, most medication to treat 'depression' and 'psychosis' is based on the popular hypothesis of a chemical imbalance of serotonin and dopamine: a theory which is, according to Healy, comparable to 'the masturbatory theory of insanity', prevalent in the nineteenth century. Healy, quoted in Robert Whitaker, *Anatomy of an Epidemic* (New York: Random House, 2015), p. 75.

[39] Andrew Scull, *Madness in Civilisation: A Cultural History of Insanity* (London: Thames and Hudson, 2015), p. 190.

Modern psychiatric publications look back on the nineteenth-century model with scorn, berating the crude and unenlightened methods of 'care'. Renowned psychiatrist Jeffrey Lieberman, past president of the American Psychiatric Association who oversaw the composition of the *DSM-5*, observed that 'in the late nineteenth century, asylums used injections of morphine and other opiate-derived drugs to subdue recalcitrant inmates […] the practise was discontinued once it became clear that opioids turned patients into hardcore addicts'.[40] However, in our Western, twenty-first-century context, prescriptions for addictive, powerful and potentially damaging psychotropics are commonplace, justified by flawed scientific theories and questionable trial results.[41] This reliance on medication culture 'reveals much about the capacity of a society to cling to a belief in the magical merits of a pill, even though clinical trials produce […] disparaging results'.[42] Long-term use of medication allegedly curbs financial strain on the mental health system, reducing the likelihood of hospitalisation and, of course, cutting overheads (a pill is drastically cheaper than a course of therapy: as observed in an article in *The Telegraph*, 'the drugs are often doled out because they are cheaper').[43] Psychotropics are also extremely lucrative for pharmaceutical companies, adding an extra incentive for potentially damaging trial results to be obscured: in 2003, for example, 'antidepressants were the single most profitable class of drugs for drug companies worldwide'.[44] Although Lieberman may ridicule nineteenth-century asylum staff who unwittingly created 'hardcore addicts', he does so from the top of a profession whereby

[40] Lieberman, *Shrinks*, p. 173.
[41] Consider the history of fluoxetine (most commonly referred to as its trade name, Prozac), 'the most widely used antidepressant in history, prescribed to 54 m[illion] people worldwide' (Anna Moore, 'Eternal Sunshine', *The Guardian*, 13 May 2007 <http://www.theguardian.com/society/2007/may/13/socialcare.medicineandhealth> [accessed 9 July 2015]).This is despite the drug being deemed 'totally unsuitable' for treating depression by the German licensing authority after its initial review: see Whitaker, *Anatomy*, p. 288.
[42] Whitaker, *Anatomy*, p. 153.
[43] Laura Donnelly, 'Anti-Depressants 'No More Effective Than Counselling', *The Telegraph*, 8 December 2015 <http://www.telegraph.co.uk/news/health/news/12039952/anti-depressants-vs-counselling.html> [accessed 2 April 2016].
[44] Daniel J. Carlat, *Unhinged: The Trouble With Psychiatry – A Doctor's Revelations About a Profession in Crisis* (New York: Simon and Schuster, 2010), p. 106.

'the needs of the patients are ignored in favour of the political needs of their treating psychiatrists'.[45]

Both the first and second generations of psychotropics – the result of psychiatry's conceptualisation of a biological model of mental illness, and symbols of scientific 'advancement' – 'trace their origins back to Macleod's deep sleep therapy at the dawn of the twentieth century'.[46] Benjamin Rush, one of the founders of American psychiatry, relied on somatic treatments, inventing the Rotational Chair (designed to improve 'patients'' circulation, 'until his [the 'patient's'] psychotic symptoms were blotted out by dizziness, disorientation and vomiting'); the Tranquiliser Chair ('to combat excessive mental input […] depriving him [the 'patient'] of sight and sound'); and 'his own customized "Bilious Pills" […] Opening up the bowels, Rush attested, expelled any deleterious substances causing mental illness'.[47] Considering psychiatry's consistent dependence on dubious bodily treatments, it is, indeed, appropriate that Rush's face remains on the official American Psychiatric Association emblem to this day. In the shadow of psychiatry's absurd and outlandish quest for the 'cure' (or just the aetiology) of 'madness' is a quiet, often unspoken, narrative of suffering: of the individual forced into the rotational chair; of the 'patient' who never awoke from deep sleep therapy; the memories lost after electroconvulsive therapy; the identity distorted after numerous diagnostic labels have been applied; the 'service user' in constant pain from irreversible tardive dyskinesia as a result of a continuous over-prescription of antipsychotics.[48]

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[45] Rogers, *Sociology*, p. 161.

[46] Lieberman, *Shrinks*, p. 176. Scottish psychiatrist Neil Macleod first trialled deep sleep therapy at the end of the nineteenth century, whereby 'barbiturates were employed to produce deep, prolonged sleep as a means of disconnecting the mentally ill from their mad thoughts' (Scull, *Madness in Civilisation*, pp. 308-09). According to Lieberman, benzodiazepines and major tranquilisers are based on this model of perpetual sedation, although modified in order for the individual – theoretically – to continue functioning.

[47] Lieberman, *Shrinks*, p. 62.

[48] A brief definition of tardive dyskinesia can be found on the Mind website: 'Dyskinesia literally means "trouble with movement"; "tardive" means delayed or late-appearing'. For more information, see Mind, 'Tardive Dyskinesia' <http://www.mind.org.uk/information-support/types-of-mental-health-problems/tardive-dyskinesia/#.VazyV_lViko> [accessed 16 April 2015].

We continue to prioritise the categorisation and medicalisation of 'madness' because it is a way of not listening, of not acknowledging the true 'authority' of 'madness' and its silenced history. Statistics declare that one in four of us will experience a form of mental illness over the course of our lives.[49] We are surrounded by *experts by experience* and yet silence their 'authority' in favour of an obsolete and outdated psychiatric narrative. We are currently caught in a catch twenty-two: psychiatry creates a hypothesis about what 'madness' is or how it should be managed (this remains hypothetical, as 'few laypeople realize how little we [psychiatrists] actually know about the underpinnings of these disorders').[50] This 'mythology [of psychiatric understandings of 'madness'] defines our present', it bleeds in to popular culture, it shapes the public imagination.[51] This is the foundation for cultural (mis)understandings of 'madness' which, inevitably, shape not only the prognosis of 'illness', but the social identity of those labelled 'mad': 'it turns out that how a people in a culture think about mental illnesses […] influences the diseases themselves'.[52] How do we escape this cycle? How do we place the individual experience at the centre of this narrative, rather than banishing it to the margins?

Popular Culture versus Lived Experience: Discourses About 'Madness'

Not far removed from totalitarian asylum culture, compliance with psychiatric 'authority' is the cornerstone of the current 'care in the community' model. This is how we have transitioned from incarcerating 'madness' to labelling and medicating it from a psychiatrist's office rather than the asylum space. 'It is the discourses of and around mental health that set the conditions of possibility for talking about mental health', and hegemonic narratives deem

[49] Mind, 'Mental Health Facts'.
[50] Carlat, *Unhinged*, p. 75.
[51] Mark Rapley, Joanna Moncrieff and Jacqui Dillon, 'Carving Nature at its Joints? *DSM* and the Medicalization of Everyday Life', in *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition* (London: Palgrave Macmillan, 2011), pp. 1-9 (p. 2).
[52] Ethan Watters, *Crazy Like Us: The Globalization of the Western Mind* (London: Robinson, 2010), p. 2.

any challenge – a refusal to take medication, questioning a diagnosis – a 'lack of insight'.[53] Although psychiatry now has tools which were not available to the nineteenth-century alienist, the dominant discourse is still one which deprives the rights and dismisses knowledge of the individual. We still speak of 'madness' in the same terms, and the outcomes for those experiencing mental illness have not improved.

But how has this narrative shaped popular culture? How does our desire to eradicate stigma coexist with our reliance on an 'authority' which, historically, legitimised inflicting brain damage under the pretence of psychosurgery, and continues to perform electroconvulsive therapy on 'patients' while unable to offer any scientific rationale? Which sources of (mis)information continue to perpetuate the social and psychiatric myth that 'madness' requires psychiatric intervention, that it is something 'other' and alien, that we should listen to those who 'treat' 'madness' rather than those who experience it?

In order to comprehend the influence of hegemonic discourse, it is necessary to investigate a variety of sources in popular culture which reproduce and reinforce psychiatric narratives. This is more a cross-section of sources, and not a comprehensive collation. The sources from popular culture that I have chosen are required to meet the following criteria to ascertain how they function as an accessible source of (mis)information about 'madness': they must be available to a mainstream audience, and must address an experience of 'madness'. With this in mind, I will examine 'Hurricane Neddy' (1996), an episode of *The Simpsons*, in which Ned Flanders, neighbour to the Simpsons family, is incarcerated and treated for an apparent breakdown. As a point of comparison, I explore 'Broken: Part One' (2009), an episode of *House*, which follows misanthropic protagonist Gregory House's experience of incarceration at Mayfield Psychiatric Hospital. Finally, I will look at an episode of *Peep Show* – aptly titled 'Sectioning' (2005) – in which Merry, a friend of the

[53] Speed, 'Discourses of Acceptance', p. 125.

protagonists, suffers from what is termed a 'manic episode' and is hospitalised. This cross-section of genres allows for an investigation of how these narratives translate to different target audiences. Despite the geographical diversity, all three of these sources present both a 'mad' character, and a psychiatric presence, meaning that these narratives offer both a commentary on what 'madness' is, and how it should be dealt with, in a Western context. They also offer insight into how psychiatric forces are socially perceived.

'Ned, You So Crazy': 'Madness' in 'Hurricane Neddy'[54]

The popularity of *The Simpsons* cannot be disputed: its pertinent commentary on American life has ensured its longevity: it has been running since 1989, and, to date, has aired 574 episodes. Attracting 'an estimated 33.6 million viewers', *The Simpsons* is well-placed to explore topical or controversial issues in an influential manner.[55] So, what happens when Matt Groening's animated sitcom decides to portray mental illness? How does this feed into – or challenge – current societal discourses on 'madness'?

Written by Steve Young and directed by Bob Anderson, 'Hurricane Neddy' first aired in December 1996. The episode focuses on Ned Flanders, a reoccurring character: neighbour to the Simpsons family; a devout Evangelical Christian who, despite consistently demonstrating compassion to his neighbours, is ridiculed and despised by Homer Simpson. At the beginning of the episode, a hurricane strikes Springfield and somehow only destroys Ned's home, resulting in Ned challenging his faith in God. The townspeople rebuild his house, but in an inferior manner, and it soon collapses again.

At this point, Ned's calm and tolerant demeanour finally slips. His characteristic verbal tics (such as his catchphrase 'okily-dokily') take a darker turn: 'Neddilly-diddilly-

[54] 'Hurricane Neddy', *The Simpsons*, 29 December 1996. Unless otherwise indicated, all subsequent quotations are from this source. I have transcribed all quotations from television programmes myself.
[55] Anthony Cody, 'The Simpsons in the News', *The Telegraph*, 27 September 2011 <http://www.telegraph.co.uk/culture/tvandradio/8792003/The-Simpsons-in-the-news.html> [accessed 7 March 2015].

diddilly-diddilly-diddilly. They did their best. Shodilly-idilly-iddilly-diddilly. Gotta be nice. Hostility-diddilly-diddilly-diddilly- Aw, hell! Diddily-ding-dong crap!' We later learn the reason behind Ned's distinctive speech patterns. However, for the moment, it is worth considering this semantic representation of the genesis of Ned's 'madness'. Ned loses control of his language: the contrast between what is later termed 'nonsensical jabbering' and rational fragments ('They did their best', 'Gotta be nice') is used to signify a conflict between Ned's 'sanity' and 'insanity'. It immediately evokes psychiatric discourse, in which 'it became standard to refer to what mad people said […] through terms such as "chattering", "jabbering" and "ranting"'.[56] This trope further perpetuates the myth that 'madness' narratives are 'closed', 'incomprehensible' texts, not worthy of interpretation. If something is 'nonsensical', it is characterised by an absence of reason or wisdom, a Lacanian term which constructs 'madness' as a deviation from knowledge.

Ned's 'madness' is indicated by dishevelled hair (a nod to the trope that 'madness' conforms to visual stereotypes) and a drastic change from his usually overly polite manner. He is taken to 'Calmwood Mental Hospital': a vast building isolated from the population of the town, surrounded by high, daunting walls. On entering the building, Ned converses with a nurse:

> Ned. I'd like to commit myself.
> Nurse. Very well. Shall I show you to your room, or would you prefer to be dragged off kicking and screaming?
> Ned. Ooh, kicking and screaming, please.

Ned, despite voluntarily admitting himself, is immediately taken to an isolation room which has padded walls. He is placed in a straight-jacket: the first scene which reveals this shows him contentedly leafing through the pages of a magazine using his toes. In addition to representing a psychiatric environment based on politics of confinement and control, this narrative also informs the audience that 'madness' *requires* such management.

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[56] Porter, *Social History*, p. 32.

Ned's current mental state is explained as a form of regression as the result of an experimental therapy he was exposed to as a child. The psychiatric presence – Dr Foster – explains that 'from that point on, any time you felt angry you could only respond with a string of nonsensical jabbering'. Foster overrides Ned's memory with details of his medical history, reconstructing Ned's past: Foster is the 'authority' on Ned's identity. As Ned is rendered a passive 'patient' who requires psychiatric intervention in order to understand himself, the narrative further perpetuates the belief that 'madness' cannot recognise itself, and thus cannot be managed by the self. It necessitates the presence of psychiatric 'authority'.

The narrative of how 'madness' should be dealt with in 'Hurricane Neddy' is complicated when the Simpson family visit Ned. The Simpsons are forced to wear labels which declare them 'sane', simultaneously enforcing the gulf between 'us' and 'other' and exposing the arbitrary nature of such distinctions (after all, if one needs to be visibly identified as 'sane', that suggests that there is a possibility that they may be assumed to be otherwise). There is potential for this discourse to destabilise the idea that 'madness' conforms to visual stereotypes, despite Ned's dishevelled hair implying a reinforcement of this idea: if 'madness' *is* visually apparent, there would be no need for such labels.

However, immediately after this visual demarcation occurs, Dr Foster informs the family that 'you folks are free to roam the grounds. Just remember, one of our patients is a cannibal. Try to guess which one. I think you'll be pleasantly surprised'. Seconds ago, there was the possibility that 'Hurricane Neddy' could be subtly challenging hegemonic narratives by suggesting that the 'sane'/'insane' binary was fluid, and potentially unstable. Now, Dr Foster – the 'authority' on 'madness' – is blurring the lines between 'madness' and abhorrent, violent and criminal behaviour, by evoking the taboo of cannibalism. He invites the Simpsons to try and identify the cannibal, thus encouraging them to be voyeurs, to witness the spectacle of 'madness', neutralised and detained by psychiatric forces. The Simpsons are cast into a

pseudo-psychiatric role, urged to categorise the 'patients' they encounter, much like the psychiatric process of consulting the *DSM* and applying labels.

There are, however, a few subtle suggestions that 'Hurricane Neddy' is not blindly *re*presenting and feeding back into hegemony. When the episode depicts a flashback to Ned's childhood, the disobedient child is seen climbing Dr Foster's bookshelf, at which the psychiatrist cries: 'Hey! Hey! Get down from that bookshelf, please! Most of those books haven't been discredited yet'. There is a suggestion here that the 'authority' of Dr Foster could be questioned. Ned's insubordinate behaviour is perceived to be the result of a lack of discipline: an almost Laingian concept which places the responsibility of the mental health of the child with the family unit, specifically the parents.[57] By evoking anti-psychiatric narratives, 'Hurricane Neddy' could be implying that hegemonic discourse is not the only 'authority' on 'madness'. The experimental therapy Ned received is called 'University of Minnesota's Spankelogical Protocol': a clearly absurd 'treatment' that consists of young Ned being spanked constantly by Dr Foster for eight months. By representing psychiatry as potentially misguided, and a force which essentially advocates child abuse, 'Hurricane Neddy' could be perceived as challenging psychiatric hegemony.

Although his 'therapy' is represented as quackery, and the 'authority' of Dr Foster is compromised, Ned does recover. On his release, Ned's return to mainstream society is marked by a crowd of his neighbours welcoming him as he steps out of the hospital. Ned announces to the crowd: 'thanks, everyone. I'm all better now', trivialising the long-term struggle many have with mental illness. The implicit message here is that psychiatry has 'cured' Ned almost immediately, thus reinforcing the 'authority' and wisdom of psychiatry.

This rapid 'cure' could represent a fragment of hope: Ned's 'madness' is deemed a

[57] In *The Divided Self*, Laing observed: 'there may be some ways of being a mother that impede rather than facilitate or "reinforce" any genetically determined inborn tendency there may be in the child towards achieving the primary developmental stages of ontological security. Not only the mother but also the total family situation may impede rather than facilitate the child's capacity to participate in a real shared world, as self-with-other'. See Laing, *Divided*, p. 189.

temporary divergence from 'sanity', and, once recovered, Ned is welcomed back into society. However, Ned's 'madness' appears to be residual: Ned advises his neighbours that he will 'run you down with my car' if they irritate him, further affiliating 'madness' with violence and criminality. The final line of the episode is attributed to Homer Simpson, who comments: 'Ned, you so crazy'. The viewer may interpret Ned's breakdown and subsequent recovery as a testament to psychiatric expertise. However, Homer's closing line suggests that once psychiatric intervention occurs, the individual who is branded 'mad' can never shed that label. This *could* be perceived as a failure on psychiatry's part, or even a commentary on cultural stigma. However, the dominant and enduring message of 'Hurricane Neddy' seems to be that Ned's aggression and potential for violent behaviour demonstrate that a full return to 'sanity' is not possible. Thus, the binary of 'mad' and 'sane' enforced by psychiatry is upheld, as Ned is unable to move fluidly between states.

'I Was Deluded Into Thinking I Might Be Crazy': 'Madness' in 'Broken: Part One'[58]

American medical drama *House* presents an interesting paradox when eponymous, esteemed diagnostician Gregory House is admitted into Mayfield Psychiatric Hospital, following a prolonged period of substance misuse and hallucinations. Simultaneously embodying the role of 'patient' *and* medical 'authority', House's incarceration has the potential to undermine hegemony by presenting a 'mad' individual who is hyper-vigilant of, and thus able to manage, his own 'madness'. Reaching an estimated audience of 16.5 million viewers, 'Broken: Part One' was aired in September 2009, and follows House's experiences in a psychiatric institution during a traumatic detox.

The opening of the episode is assembled using quick cuts to signify House's disorientation, and his intermittent consciousness. The focus on images such as House's

[58] 'Broken: Part One', *House*, 21 September 2009. Unless otherwise indicated, all subsequent quotations are from this source.

hospital ID bracelet; a nurse watching House from the door to his room; and the restraints which shackle House to the hospital bed, reconstruct House's identity as that of 'patient' rather than doctor. During the opening sequence, House fluctuates between vulnerability (exhibited by him lying in the foetal position) and aggression (punching the door to his room several times). Both of these roles evoke hegemonic discourse, representing 'madness' as a state of 'otherness'. Initially, we are able to witness the trope of the infantile 'mad' individual who requires psychiatric intervention in a pseudo-parent role (consider the extract I discussed earlier from the *Oxford Handbook of Psychiatry*, which compared sectioning to 'lifting and holding a two-year-old having a tantrum').[59] House's display of aggression and hostility reinforces the marriage of 'madness' and violence, as such alleged 'violent tendencies' dominate societal preconceptions of those experiencing mental illness.[60]

Once House has completed his detox, he demands to leave: considering his voluntary admission, such a request is not unreasonable. House explains that he only admitted himself as 'I was deluded into thinking I might be crazy': a suitable oxymoron for House's liminal 'patient'/doctor state. Dr Nolan, the psychiatric presence, informs House that although he is legally 'free to go' whenever he wants, Nolan will not write the letter of recommendation to the board of medicine (necessary for House to continue practising medicine) unless House allows himself to be transferred to the long-term ward and cooperate with treatment. Although there is potential for the ethics of the psychiatric presence to be undermined here, with House demanding 'Is that a popular new treatment – blackmail?', regular viewers of the show would recall House's increasingly erratic and reckless behaviour (such as self-administering insulin shock therapy; inserting a cochlear implant into a 'patient' without their permission; and pretending to have cancer) and be forced to agree with Dr Nolan. As House is now constructed as a 'patient', he is portrayed as showing a lack of insight into his mental

[59] Semple, *Handbook*, p. 16.
[60] Cross, *Mediating Madness*, p. 33.

state and his ability to do his job. Much like Flanders's inability to return to 'sanity' at the end of 'Hurricane Neddy', it appears that House's new identity as a 'patient' has overridden his previous status as a medical professional.

House's response to psychiatric 'authority' is one of hostility: his role as 'patient' demands that he 'agree[s] to take meds, participate[s] in group and individual therapy [and] work[s] on goals'. Further perpetuating the myth of aggression and lack of insight, House warns that 'I can smile through gritted teeth and play nice, but there are serious risks of violence involved in that choice'. However, seeing no other option, House is transferred to ward six to undergo further 'treatment' in order to meet Dr Nolan's requirements.

Shortly after House's transfer, the viewer is introduced to his roommate, Alvie, who is escorted to the room by a nurse. Agitated and animated, Alvie's initial interaction with House (and with the viewer) is telling:

> Who are you? You believe these guys? Lecturing me on manic depression, like I couldn't write a book or two. I stop taking my meds because I want to stop taking my meds, because nothing is wrong with me. No reason to keep dragging me back here. When I'm on them, everything slows down. That's when the problem is.

Alvie believes that he is the 'authority' on his 'madness', assuring House that he could 'write a book or two': a stance of knowledge which threatens to challenge the 'mad'/'sane' knowledge/non-knowledge binary. Alvie represents psychiatric resistance by refusing the drug-based model of care that is enforced on him. He believes medication is the *cause* of the 'problem', rather than its 'cure'.

However, those around Alvie display open irritation towards him: he mentions that 'my roommate last time couldn't stand me', and House snaps at Alvie: 'shut up. No one likes you'. This suggests that Alvie, like House, is also displaying a lack of insight into his conduct and his mental state. The character of Alvie is thus reinforcing the trope that 'madness' requires psychiatric management. Alvie revels in the pace of his thoughts, and is dismissive of any indication that this perceived abnormality should be controlled by medication: 'they

[the psychiatrists] tell me my mind works too fast. [They would] probably tell Usain Bolt he runs too fast'. However, as the episode unfolds, there is clearly a strong implication that Alvie's rash and excitable temperament needs to be curbed, particularly as his behaviour allows House to exploit him (Alvie permits House to attack him as part of House's scheme to acquire phone privileges), and he becomes reckless (Alvie sells some of House's valuable possessions later in the series). As with House's earlier fluctuation between defencelessness and aggression, Alvie is characterised by contrasting states of vulnerability (suggesting he needs to be looked after) and potentially dangerous impulsiveness (suggesting he needs to be managed). Thus, the underlying message appears to be that Alvie's claim that 'nothing is wrong with me' has been suppressed by psychiatry's insistence that his mental state is abnormal, and requires 'treatment'.

An enlightening contrast to Alvie's resistance can be found in the character of Hal. Hal's real name is Connor, but he is referred to as 'Hal' due to his reliance on Haldol (the trade name of typical antipsychotic haloperidol), which the nurses refuse to give him, despite his feigned seizure at the beginning of the episode. House quickly deduces that Hal is suffering from anorexia nervosa, exhibited through his unremitting concerns regarding eating and weight. The vast majority of Hal's interactions concern either his issues with food, or his desire for Haldol. Indeed, the latter has proven such a prominent feature of his identity that it has *become* his identity, as demonstrated by his name. Hal's 'madness' has consumed him to the extent that his character remains undeveloped: in the psychiatric realm, the only salient information is his diagnosis and his medication (a residual side effect of the *DSM* and medication-based approach). Hal consistently cooperates with psychiatric forces, and is the only 'patient' on the ward who has earned the highest tier of privileges, allowing him to use the phone (which makes him a target for House, who covets his phone card). He is constructed as a model 'patient', but nothing more.

House's paradoxical role as 'mad' 'patient' with a doctor's knowledge allows him to observe and participate in the politics of this psychiatric environment. House is both the spectacle and the observer. During a group therapy session, House asks 'can I get a pen?', foreshadowing his ability to detect and retain sensitive information which he later uses to manipulate the other 'patients'. Although the gathering of this information evokes his previous identity as a diagnostician, his use of it is cruel, aligning his behaviour with a rejection of social norms and codes (an 'otherness' indicative of 'madness'). As the 'patients' participate in a game of basketball, Dr Beasley encourages House: 'just talk. Be honest […] Try to deal with people'. House responds to this psychiatric 'authority' with his own display of power:

> House [*to Richter*].
> - The CIA satellites aren't watching me. They're watching you, 'cause you're wearing green.
> [*As Richter tears off his sweater and throws it on the ground, House turns to Dr Beasley*].
> -That one was just too easy
> [*Turning to Hal*].
> -Seriously, anorexia? What, are you supposed to be a girl? And, in answer to your implicit question, yes, those pants do make you look fat.
> [*Hal backs away quickly. House looks around and sees Susan standing under the basket*].
> -How upset were you when you woke up in the ER and you were still alive and a failure?
> [*She turns and walks away. House looks at Beasley*].

These hyperbolic stereotypes of 'madness' (the intense paranoia, the perceived vanity of an eating disorder, the self-destructive tendencies exhibited by a suicide attempt) reinforce over-simplistic assumptions of what 'madness' is. The fact that House's observations clearly hit a nerve with the 'patients' suggests to the viewer that these assumptions are, in fact, true. The features of 'madness' that are emphasised to the viewer are those which draw attention to perceived abnormalities: as none of these characters are developed any further than their diagnosis and their 'otherness', their 'madness' is the defining feature of their characterisation. Their actions and their dialogue are permitted only to reflect their illness,

thus the viewer is likely (unless they have personal experience of such supposed abnormalities) to be unable to forge an empathetic relationship with these characters. Such characters are not developed beyond the tropes of their 'madness', therefore reinforcing the trope that to be 'mad' is to be 'other'.

House's desire to challenge psychiatric 'authority' leads him to embark on a friendship with a new 'patient', Freedom Master. Freedom Master believes that he can fly, hence his superhero inspired name (to which Alvie responds 'Coooool. We got more Jesuses than superheroes', further reinforcing over-simplistic stereotypes of the 'deluded' individual to the viewer). Freedom Master is characterised by his illness – specifically, his 'delusion' – which fortifies the trope that the 'mad' individual is unreliable and out of touch with 'reality'. Echoing the methodology of Dr Maillard in Poe's 'The System of Doctor Tarr and Professor Fether' (whose radical system consisted of 'encouraging' the 'delusions' of those committed: 'we contradicted *no* fancies which entered the brains of the mad. On the contrary, we not only indulged but encouraged them'), House listens to and responds to Freedom Master's 'delusions' by taking him to a free-fall flight simulator at a local fairground.[61] With his belief in his ability to fly reinforced, Freedom Master launches himself off a building, and ends up gravely injured. House is reprimanded by Dr Nolan:

> He's lucky to be alive. He's got a lacerated spleen, rotational pelvic fracture, compound break of the femur and humerus. Everything in your life has been about finding the truth. But suddenly, with this guy, you decide to reinforce a sick man's delusions.

Although this scenario is complicated by House's oxymoronic 'patient'/doctor role, the message is clear: entertaining or even just acknowledging the 'delusions' of the 'mad' is *dangerous*. Such 'delusions' should be dismissed and medicated, not listened to: doing so is

[61] Poe, 'Tarr and Fether', p. 268. Both House and Maillard embody the paradox of 'patient'/doctor. This empathetic approach – of listening to and attempting to understand 'madness' – seems only to feature when the psychiatric presence is, in fact, 'mad' too.

damaging to the 'patient'. Yet again, 'Broken: Part One' reinforces hegemony by suggesting that only psychiatry is able to manage 'madness'.

'Downside: Might Get Lobotomised': 'Madness' in 'Sectioning'[62]

Compared to *The Simpsons* and *House*, cult comedy *Peep Show* attracted modest viewing figures, with an estimated 'total audience of around 1.5 million' during its initial airing, although part of this difference may be attributed to its UK, rather than US, origins and audience.[63] However, it has been celebrated as an accurate representation of the trials and tribulations of twenty-something British life: *The Independent* commented on how it 'never stop[s] being relevant'.[64] So, what happens when a show revered for its relatability tackles something as socially strange and 'other' as 'madness'?

Rather than the tactic used in *The Simpsons* – making a previously familiar and 'sane' character 'mad' – *Peep Show* introduces a new character to portray 'madness'. Merry is a friend of protagonists Mark and Jeremy from their time at Dartmouth University, and only features in this episode, therefore her character remains undeveloped. As with the 'patients' we encounter in *House*, the focus is primarily on Merry's apparently abnormal behaviour, thus her 'madness' is portrayed as *the* fundamental component of her identity.

Merry recently purchased a pub, and Mark and Jeremy visit as she has offered Jeremy a job running it. Merry's first 'mad' trait is revealed: her overt sexuality. Evoking archaic nineteenth-century discourses which rendered a woman 'mad' if she exhibited any manner of sexually 'deviant' behaviour (or, indeed, *any* manner of sexual behaviour), Mark discusses

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[62] 'Sectioning', *Peep Show*, 25 November 2005. Unless otherwise indicated, all subsequent quotations are from this source.
[63] Viewing figures taken from 'The Event Struggles with a 3.1% Audience Share', *The Guardian*, 29 November 2010 <http://www.theguardian.com/media/2010/nov/29/the-event-audience-share> [accessed 7 March 2015].
[64] Christopher Hooton, 'Peep Show Season 9 Finale Review, Channel 4: The El Dude Brothers Go Out With a Whimper, Appropriately', *The Independent*, 16 December 2015 <http://www.independent.co.uk/arts-entertainment/tv/reviews/peep-show-season-9-final-episode-review-channel-4-the-el-dude-brothers-go-out-with-a-whimper-a6775636.html> [accessed 3 April 2016].

his concerns with Jeremy: 'I think something's wrong with Merry. She made a pass at me […] I'm worried about her. She's not right in the head'. Jeremy defends Merry's eccentricities with an assortment of clichéd colloquialisms: 'She's always been a bit full on. She's kooky […] maybe she is a bit up and down'. As Merry's behaviour becomes more and more erratic – such as turning up at Mark and Jeremy's flat with a baguette and a tin of paint – Mark grows increasingly concerned. Finally, action is taken:

> OK, OK, I guess we've just got to bloody take responsibility, haven't we?
> [*picks up phone and dials*].
> -Hello, NHS Direct? Hi. Listen, I want to get my friend sectioned. Yes, but I don't know what the procedure is? How easy would that be to do? Would I have to be involved or could I just give you the house number and assure you that she's mental?

Mark feels that Merry is unable to manage her 'madness' and thus calls on the 'authority' by requesting to have her sectioned.

However, the theme of sectioning is in the episode solely for comedic effect. It is a ploy used by Jeremy to try to rid him of his friend Hans when his presence becomes inconvenient:

> Hans. Well somebody tried to get me sectioned and nobody gets Super Hans sectioned.
> Jeremy. Well, I definitely didn't try to get you sectioned.
> [*Internally*: That sounded pretty convincing].
> I guess it was just one of those freaky urban things like those people who go on fire for no reason.

The entire process of psychiatric intervention is trivialised, with Jeremy internally musing: 'if I got sectioned, I'd put up more of a fight. Downside: might get lobotomised'. This nod to psychiatry's controversial past (and the associated public outcry) could be perceived as an attempt to undermine psychiatric 'authority'.[65] However, as I shall demonstrate, Jeremy's

[65] Along with electroshock therapy, the psychiatric practice of leucotomy (or lobotomy, as it is most commonly referred to) is firmly entrenched as a symbol of psychiatric tyranny. Through his development of this procedure in 1935, Portuguese neurologist António Egas Moniz was awarded the Nobel Prize in 1949 'for his discovery of the therapeutic value of leucotomy in certain psychoses', and he is generally regarded as the founder of psychosurgery. His treatment 'was celebrated as a miracle cure […] After a relatively simple surgery, endlessly troublesome patients could be rendered docile and obedient. Leucotomies spread like wildfire through the asylums of both Europe and America'. See Lieberman, *Shrinks*, pp. 162-65. The procedure itself consisted of

understanding of 'madness' and psychiatry is shown to be misinformed, and his actions and speech fuelled by greed, rather than any desire to empathise with Merry's experience or genuinely question the care that she receives.

When Merry is sectioned, Mark, Jeremy and Hans go to visit her. Jeremy is keen to get Merry released as a matter of urgency, and so attempts to normalise her 'mad' behaviour to the psychiatrist on duty:

> Psychiatrist. I'm afraid Merry needs to be kept a close eye on just now.
> Jeremy. But she's fine. She's always been the life and soul. Tabasco in your pint, Frisbee in the kitchen, that's Merry. She's kooky.
> Psychiatrist. She's in the acute stage of a manic episode.

As with his earlier use of colloquialisms, Jeremy's assertion that Merry's behaviour is rooted in eccentricity rather than 'madness' sets him up in opposition to the psychiatric presence which medicalises Merry's experience. However, during this exchange, Jeremy's idiomatic language ('she's kooky') is overridden by the psychiatrist's medicalised terminology ('She's in the acute stage of a manic episode').[66] Psychiatry, immediately able to offer a label and thus a form of justification for Merry's behaviour, is shown to *understand* Merry better after a brief assessment than someone who has known her for a decade. Psychiatry's dominance is upheld.

However, Jeremy continues to attempt to challenge psychiatric 'authority':

> Jeremy [*to the psychiatrist*]. Your little world is threatened by all the amazing Jack Nicholsons and Robin Williamses burning so bright you've got to keep them down with your chemical cosh […] Your dream is just everyone on the omnibus, grey, eating grey sludge.

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drilling into the skull and inserting a knife into the frontal lobes and slicing out brain tissue. The precarious scientific theory behind Moniz's treatments – 'that mental illness resulted from "functional fixations" in the brain [which] occurred when the brain could not stop performing the same activity over and over, and Moniz asserted that the leucotomy cured patients by eliminating their functional fixations' – has been denounced by modern psychiatrists as 'pure cerebral mythology'. Continuing the trend of invasive and horrific somatic treatments with little or discredited scientific justification, we must remember that – as historian Andrew Scull pointed out - in the first half of the twentieth century, such procedures were the cornerstone of care for the overwhelming majority of 'patients'. See Scull, *Madness in Civilisation*, p. 322.

[66] Use of the definite article here ('the acute stage') reveals a homogenisation of lived experience. Merry is not described as experiencing *an* acute stage, but '*the* acute stage', thus exposing an assumption that 'manic episodes' consistently follow the same trajectory. This statement entirely ignores the significance, context and experience of the individual.

> […]
> Hans. She's just wacky, basically fine.
> Mark. She's not fine, she's temporarily mad.
> Jeremy. You're with them now, are you, Mark? Tell me, is it mad to be diagnosed with a mental disorder or is it in fact much more mad to get up every morning to go to your boring job so you can print out lots of meaningless documents?
> Mark [*to the psychiatrist*]. I'm sorry about this, it's the '60s' he thinks he's living in the '60s.

Jeremy's reference to Jack Nicholson evokes *One Flew Over the Cuckoo's Nest*. This goes some way to explaining Jeremy's earlier mention of a lobotomy: it suggests that Jeremy's knowledge of 'madness' is an amalgamation of fictional accounts and outdated information. Thus, although Jeremy is staging a rebellion against psychiatry, his stance is weakened by his use of questionable information (and, later on, his dubious motivations). Fuelled by his familiarity with *One Flew Over the Cuckoo's Nest* – a tale of totalitarian 'authority', embodied in the 'Combine', which suppresses individuality and punishes with psychiatric 'therapies' those who do not conform – Jeremy's argument verges on the political, accusing the psychiatrist of desiring conformity and institutionalisation, not just for his 'patients' but for 'everyone'.

Jeremy's increasingly socio-political speech is undermined by a mortified Mark (who is, throughout the show, the more grounded and practical of the two protagonists). He apologises to the psychiatrist and explains that 'he thinks he's living in the '60s'. However, the final factor which completely deconstructs Jeremy's argument is the revelation of his true motivations. Merry had, during her alleged 'manic episode', offered Jeremy and Hans the deeds to the pub, at no cost. Jeremy's impassioned, anti-psychiatric speech was, in fact, a ploy to get her released as quickly as possible in order for her to hand over the deeds, and, presumably, so the transaction was not obstructed by the Mental Capacity Act. As soon as Jeremy learns that Merry has given Mark the paperwork, Jeremy no longer has any need for Merry to be released, and so his anti-psychiatric attitude quickly vanishes. He tells the psychiatrist: 'OK, fair enough, mate, I've said my piece, but you win. After all, *you're the*

expert'. This abrupt change of Jeremy's opinion leaves a significant impression on the viewer. The implication is that psychiatry is not only 'the expert', but also a protective force, able to defend those it simultaneously labels 'mad' from any who seek to prey on such vulnerability. Compared to Jeremy's mercenary behaviour, psychiatry is depicted as a benevolent presence, able to act in Merry's best interests when she is unable to make such judgements. Anyone who challenges psychiatric 'authority' *must* be doing so with ulterior motives.

'We Invariably Rely on Cultural Beliefs and Stories': Myths of 'Madness' in Mainstream Society[67]

Despite spanning different genres, the message in these narratives remains the same. These three – *The Simpsons*, *House* and *Peep Show* – reinforce psychiatry's dominance over 'madness'. By exposing any characters who attempt to undermine hegemonic discourse as ill-informed, harbouring ulterior motives or gambling with the welfare of the 'patient', these examples of popular culture fortify the idea that only psychiatry can govern 'madness'. Although *House* and *Peep Show* present a drug and *DSM*-based paradigm of care (exemplified by use of diagnostic labels and medication), suggesting psychiatry has developed from the asylum culture of the nineteenth century, all three shows present 'madness' as *institutionalised*. This representation appears to clash with 'care in the community' which champions deinstitutionalisation. By depicting Ned Flanders wearing a straight-jacket in an isolation room; Gregory House shackled to his hospital bed with ankle and wrist restraints; and Merry on a hospital ward, these discourses seem to have more in common with asylum culture than the twenty-first-century model of community care. How might this theme of institutionalisation – in a psychiatric landscape which claims to be

[67] Watters, *Crazy Like Us*, p. 6.

moving away from such measures – have prevented narratives about 'madness' from changing? How has this reoccurring trope perpetuated other myths, such as those I established at the start of this chapter?

As a point of comparison, I will now briefly move away from historical and fictionalised accounts to identify sources which enforce stigmatised assumptions about 'madness': 'cultural beliefs' which are universally relied on to (mis)understand 'madness'.[68] These will be examined as a means of establishing a societal discourse about 'madness'; the relationship this has with psychiatric tropes; and to understand how lived experience of 'madness' is still marginalised.

In September 2013, established supermarket chain Asda sparked controversy after revealing their new range of Hallowe'en costumes. The offending item was called 'Mental Patient Fancy Dress Costume': comprised of a tattered, bloodstained shirt, bloodstained plastic meat cleaver and gruesome mask, the product had a description informing potential customers that 'it's a terrifying Hallowe'en option'.[69] Asda elaborated that 'every one [*sic*] will be running away from you in fear in this mental patient fancy dress costume'.[70] Asda later withdrew this item from sale and issued a public apology, in addition to donating to Mind, a mental health charity. Despite the obvious ignorance and insensitivity behind such a product, it does provide an opportunity to observe how myths of 'madness' are established – and upheld – in mainstream society.

Here, the salient discourse is rooted in archaic constructs. The obvious marriage of 'madness' and criminality (exhibited by the weapon and the bloodstains) could be straight out of Lombroso's 1876 publication, *Criminal Man*. The representation of 'madness' as a spectacle echoes the staff at Bethlem hospital 'seiz[ing] a marketing opportunity by allowing

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[68] Ibid.
[69] 'Asda Withdraws "Mental Patient" Halloween Costume', *The Guardian*, 26 September 2013 <http://www.theguardian.com/business/2013/sep/26/asda-mental-patient-costume> [accessed 7 March 2015].
[70] 'Asda', *Guardian*.

the paying public entry to the hospital to view the inmates'.[71] Indeed, the title of 'Mental Patient' denotes an individual who is institutionalised (thus a 'patient'), a concept which seems to fit harmoniously with nineteenth-century asylum culture rather than the current 'care in the community' model.

Perhaps the most enlightening feature of this product is what it reveals about *fear*. Clearly, the suggestion that one should dress as a 'Mental Patient' to evoke terror reveals some form of societal phobia of 'madness'. However, in addition to perpetuating 'madness' myths which are positively Victorian, an analysis of what this costume represents exposes a very specific fear. Although the title suggests an incarcerated individual – the 'Mental Patient' – the weapon and the blood-spattered outfit suggest this is an escaped 'patient': an autonomous and free 'madman'. This is why popular culture portrays institutionalised 'madness': because the idea of 'madness' at large and without psychiatric management is an object of terror, so much so that it was available as an option for a Hallowe'en costume.

The same year, Tesco came under fire for a similar issue. Customer complaints mounted regarding their 'Psycho Ward' costume. This ensemble consisted of a bright orange boiler suit, branded with the word 'Committed' on the back and 'Psycho Ward' printed on the front; a Hannibal Lecter-inspired mask; and a syringe. Potential customers were invited to 'dress up as the most thrilling psycho killer character of all time in this Psycho Ward costume'.[72] Yet again, the latent social anxiety which led to the marketing of such a product is one of the fugitive – and thus autonomous – 'psycho'. The object of fear here is the institutionalised 'patient' (signified by the 'Committed' stamp) who absconds from both a psychiatric environment and psychiatric policing. The syringe – symbolic of the tools used to

[71] Cross, *Mediating Madness*, p. 49.
[72] Rebecca Smithers and Sam Jones, 'Tesco Removes 'Psycho Ward' Boiler Suit Costume After Consumer Anger', *The Guardian*, 26 September 2013 <http://www.theguardian.com/uk-news/2013/sep/26/tesco-withdraws-psycho-ward-costume-complaints> [accessed 7 March 2015].

sedate and thus control the 'psycho' – has become a weapon. Both of these costumes equate the liberation of 'madness' with the certainty of criminality, violence and murder.

In the midst of this controversy, on the 7th October 2013, British tabloid newspaper *The Sun* blazoned the following headline across its front page: '1,200 killed by mental patients'. The article declared that 'A Sun investigation today reveals disturbing failings in Britain's mental health system that have allowed high-risk patients to kill 1,200 people in a decade'.[73] As with the Hallowe'en costumes, this prime example of media sensationalism exposes and propagates a fear of the 'high-risk patients' who are reintegrated into mainstream society. The article had its genesis in an annual report which was published in July 2013 by the University of Manchester. A cursory glance at the report reveals just how misinformed and misleading *The Sun*'s headline is.

The original investigation explains that the homicide figures for those *The Sun* labelled 'mental patients' consisted of 'perpetrators who had symptoms of mental illness at the time of the homicide: People who experienced symptoms of hypomania, depression, delusions, hallucinations, or other psychotic symptoms […] were defined as mentally ill at the time of the offence'.[74] In other words, the study categorised *anyone* exhibiting symptoms – 'of all severity' – which could be interpreted as indicative of a mental illness as 'mentally ill'.[75] However, *The Sun* classified such perpetrators as 'mental *patients*': a semantic distinction which misleadingly suggests that such individuals were diagnosed as mentally ill, when actually they were just considered to exhibit *symptoms* of mental illness. The original report explained that 'on average, 67 people per year committed homicide whilst

[73] '1200 Killed By Mental Patients', *The Sun*, 7 October 2013 <http://www.thesun.co.uk/sol/homepage/news/5183994/1200-killed-by-mental-patients-in-shock-10-year-toll.html> [accessed 15 July 2015].
[74] University of Manchester, 'The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (July 2013)' <http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/AnnualReport2013_UK.pdf> [accessed 8 March 2015], p. 76.
[75] Ibid.

experiencing an abnormal mental state […] Most of these people were not under mental health care'.[76] Thus the truth is a far cry from *The Sun*'s claim that 'high-risk patients' are 'allowed' to kill due to 'failings in Britain's mental health system'.[77]

Had *The Sun* remained true to the report's use of the term 'patient' (defined as a 'person [who] had been in contact with mental health services in the 12 months prior to the offence'), the headline would have been quite different.[78] The report states that: 'during 2001-2011, 26 people convicted of homicide (13% of the total sample) were identified as patients […] this was an average of 2 patient homicides per year, ranging between 1 and 4 annually'.[79] When compared to broader statistics on homicide, *The Sun*'s argument is further undermined, as '95% of murders [perpetrated during the stated time frame] were committed by individuals who had not been diagnosed with a mental health problem'.[80] It is clear that *The Sun*'s article is, at best, the result of media hyperbole, misinterpreted statistics and writing which champions its shock value over accuracy and informed journalism.[81]

Yet the fear which underpins this sensationalist headline is obvious and telling. An equally fitting alternative to '1,200 killed by mental patients' would be 'dangerous lunatics at large due to "care in the community" initiative'. The 'disturbing failings in Britain's mental health system' to which *The Sun* refers are the result of the process of deinstitutionalisation: a 'disturbing fail[ure]' to police and incarcerate 'high-risk patients' – or, indeed, anyone labelled or even potentially labelled 'mad'.[82] Similar articles from 2013 tell the same story. An article entitled 'My schizophrenic son says he'll kill ... but he's escaped from secure

[76] Ibid.
[77] '1200 Killed', *Sun*.
[78] University of Manchester, 'National Confidential Inquiry', p. 76.
[79] Ibid.
[80] Mona Chalabi, 'The Sun Says 1,200 People Have Been Killed By 'Mental Patients' – Is It True?', *The Guardian*, 7 October 2013 <http://www.theguardian.com/society/reality-check/2013/oct/07/sun-people-killed-mental-health-true> [accessed 8 March 2015].
[81] The shock value of such journalism echoes the role of the nineteenth-century Sensation genre which, according to *Punch*, was concerned with 'Harrowing the Mind, Making the Flesh Creep, Causing the Hair to Stand on End, [and] Giving Shocks to the Nervous System'. See Anon, *Punch*, 'Sensation Times', p. 193.
[82] '1200 Killed', *Sun*.

hospitals 7 times' explains how 'a mum has told how her paranoid schizophrenic son has been able to escape from secure hospitals SEVEN times'.[83] Another article informs its readers of how 'a mentally ill man freed [and] unsupervised' committed a horrendous and fatal attack on a schoolgirl.[84] This reporting is not far removed from Kraepelin's assertion, made over a century ago, that 'all the insane are dangerous, in some degree'.[85]

In addition to reinforcing an evident fusion of 'madness' and criminality, such articles condemn the 'care in the community' model which allows the 'mentally ill' to be 'freed' and 'unsupervised'. The latent message here is that the 'mad' do not belong in mainstream society. This 'us' versus 'them' myth which dominates societal discussions of 'madness' is a direct legacy of asylum culture and is reinforced by the use of the *DSM* (which applies labels to demarcate the 'abnormal' from the 'normal'). But what does this mean for those bearing the brunt of this stigma, for those attempting to reintegrate into society, or just remain a part of it? As I have established, the representation of 'madness' in popular culture is one of sanitisation and control: the 'threat' posed by those deemed mentally ill, such as House, Flanders and Merry, is neutralised and contained in a psychiatric space. In contrast, the media and other mainstream discourses depict the autonomous and *dangerous* 'mad' individual, at large and unsupervised in society, and propagate social fear of such a figure. This establishes a binary, with the sedated and controlled 'mad' on one end, and free and violent 'mad' at the other. But what about those who occupy the liminal space in-between such extremes? What is the prognosis for such purgatory?

The Political and the Personal: Problems and Solutions

[83] 'My Schizophrenia Son Says He'll Kill But He's Escaped Secure Hospitals', *The Sun*, 8 October 2013 <http://www.thesun.co.uk/sol/homepage/news/5189349/My-schizophrenic-son-says-hell-kill-but-hes-escaped-secure-hospitals-7-times.html> [accessed 16 July 2015].
[84] 'Police and Medic's Mistakes That Led to Christina Edkin's Murder', *The Sun*, 2 October 2013 <http://www.thesun.co.uk/sol/homepage/news/5176367/police-and-medics-mistakes-that-led-to-christina-edkins-murder.html> [accessed 16 July 2015].
[85] Kraepelin, *Lectures*, p. 2.

When I talk about ‘madness’, I do so from three perspectives, often simultaneously. First of all, I approach it as an academic, from the perspective of historical research and representation. Second, I examine it from the standpoint of someone who works in the mental health system, who, on a daily basis, engages with and supports those psychiatry has labelled ‘mad’. Finally, I am inevitably influenced by my own assemblage of psychiatric diagnoses, my own experience of stigma, of medication, and of the trials and tribulations of living with a mental illness (or several, according to my medical notes).

From this academically, personally, and professionally informed vantage point, I have identified two fundamental issues with the representation of and the way we deal with ‘madness’ which, if unaddressed, will continue to enforce silence on those who desperately require a voice. These are aside from the language problem, which I have already outlined, and for which I will suggest solutions shortly. The first problem is that those who fall in-between the twin pillars of ‘madness’ in popular culture (with controlled, incarcerated ‘madness’ on one side, and unsupervised, dangerous ‘madness’ on the other) are not meaningfully represented in popular culture. This hyperbolic binary presents ‘madness’ as a dichotomy which can only be sanitised and controlled with psychiatric intervention. This means that the lived experience of the vast majority of those labelled ‘mad’ does not enter popular currency, and remains unacknowledged. The primary discourse about ‘madness’ which established this binary still enforces the societal conviction that there is no place for ‘madness’ on the social landscape. We need to instigate a dialogue which speaks of lived experience of ‘madness’, rather than the current narrative which only addresses incarcerated or apparently dangerous ‘madness’. Our representation of ‘madness’ has not moved on from asylum culture, which imposes a clear ‘us’ versus ‘them’ binary, and continues to depict ‘madness’ as a state of ‘otherness’.

This hegemonic discourse – supported by the *DSM* approach – limits those experiencing 'madness' to their 'madness', and nothing else. As I have shown, popular depictions of 'madness' (such as Hal and Merry) suggest that 'madness' is perceived as the entirety of someone's identity, that such characters are permitted only to reflect their alleged abnormalities, and little else. However, one does not cease to be a multifaceted individual once a psychiatric label has been attached. This label does not override a life of diverse experience, of relationships, of personal interests, hobbies and passions. And yet popular culture – informed by psychiatric discourse – suggests that 'madness' renders someone 2D; an identity irrevocably appropriated by a diagnostic category.

In the liminal space between the binary of 'incarcerated' and 'unsupervised' 'madness', exists the clients I support, me, members of my family, people in my social circle, students that I have taught, and colleagues with whom I have worked: individuals with so much more to their identity that their medical notes. We need to represent those who do not fit with the oversimplified, damaging caricatures I have established because lived experience of 'madness' lies in between this binary, and beyond the realm of limited and limiting psychiatric labels.

This leads me on to the second fundamental issue with societal and psychiatric attitudes to 'madness': that of the encompassing and permanent sick role. Journalist and writer Robert Whitaker observed that 'as the psychopharmacology revolution has unfolded, the number of disabled mentally ill […] has skyrocketed'.[86] With the dissolution of asylum culture and the associated removal from the social sphere, the sick role represents *metaphorical* alienation. It is the product of the new psychiatric model of medication, the *DSM*, and 'care in the community'. However, the discourse is the same as that enforced by

[86] Whitaker, *Anatomy*, p. 5.

the nineteenth-century alienist: the end result is that of social marginalisation, and a loss of self.

In order to establish what I mean by the term 'sick role', imagine this scenario. During a particularly stressful period in your life, you begin to experience sensations which, to you, are unusual. Perhaps you were confronted by a stranger during a solitary walk home one night; worry that you were followed home; or heard about a local mugging. You get increasingly anxious about leaving the house afterwards in case a similar incident occurs.[87] Perhaps this anxiety leads to intense paranoia; you begin to worry that you are being followed, or that you or your loved ones will be harmed. Over the course of several weeks, it becomes harder and harder for you to continue functioning as this anxiety and paranoia area paralysing: unable to leave the house to go to work or buy food, you remain housebound. Someone close to you is concerned for your wellbeing: when they attempt to visit you, you are overwhelmed by the worry that they may be an imposter or a spy, and you feel unable to let them in. Perhaps you know, on some level, that these beliefs are irrational, or perhaps you are entirely immersed in them: regardless, you do not feel that you can stop them. Eventually, the authorities are alerted, and a psychiatric evaluation takes place in your home as you have not felt comfortable leaving your house for a few weeks. You are placed under section 2 of the Mental Health Act.[88] You are assessed. You are told you are suffering from 'persecutory delusions' – a classic 'schizophrenic' symptom. Your section becomes a section 3, which can last up to six months. You are placed on a regime of antipsychotic medication. After several

[87] This is not intended to oversimplify the catalysts or social triggers which may contribute to an experience of 'madness', nor am I suggesting that mental illness necessitates such a trigger. This is merely for illustrative purposes.

[88] Section 2 allows an individual to be detained in hospital involuntarily for a period of up to 28 days for psychiatric assessment. See 'Mental Health Act 1983' <http://www.legislation.gov.uk/ukpga/1983/20/section/2> [accessed 30 March 2016]. An individual detained under section 2 'can't refuse treatment'. Rethink Mental Illness, 'Mental Health Act 1983 - Sections 2, 3, 4 & 5' <https://www.rethink.org/living-with-mental-illness/mental-health-laws/mental-health-act-1983/sections-2-3-4-5> [accessed 16 June 2016].

months, you are released and, under section 117 aftercare, are placed in a supported housing scheme as those around you fear you returning to your isolated and withdrawn state.

You are now in an environment which fortifies your ‘schizophrenic’ identity. You are assigned a social worker, and an outreach worker, who visit you solely to talk about your illness. You regularly meet with a psychiatrist to ensure you continue to take your medication: a daily reminder that you are ill and ‘other’. The medication brings with it a host of unwelcome side effects which, at best, make you perpetually drowsy. You are unable to work and so become state dependent. Your fellow tenants experience similar ailments. Every professional you encounter has risk assessed you and is familiar with your medical history. This environment is that of a pseudo-asylum: it is a situation which enforces the sick role by limiting your identity to that of a ‘patient’. If ‘recovery’ were to occur (a term that I use without clear definition, as it is dependent on the individual’s concept of ‘recovery’), you would still be labelled ‘schizophrenic’ – albeit ‘in remission’.

When I started working in mental health, I was slightly taken aback by how candid some clients were about divulging the details of their illness. The first conversation I had with many of them was regarding their medication, or their current symptoms. In some cases, it took months of encouragement for certain clients to feel comfortable talking to me about, for example, their family, their friends or their personal interests. It quickly dawned on me that this was primarily conditioning by the mental health system: when someone in the capacity of ‘staff’ interacts with a ‘service user’, the majority of the time that conversation revolves around their identity as a ‘patient’, rather than a *human being*.

This entrenched sick role can hinder ‘recovery’: if you are given an enduring label and put on medication that is likely to be a dominant feature of your daily routine for the foreseeable future, then those aspects of ‘identity’ which were so fundamental to the self before ‘madness’ are lost. After psychiatric intervention, it can be very difficult to retain any

sense of self which has not been distorted in some way by the momentous experience of being labelled with a mental illness. Some 'services users' do, eventually, manage to move on and rebuild their lives away from a formally supported environment, but when it does happen, it happens *despite* the mental health system, not because of it.

When I talk about the spectre of the asylum, this is what I mean. Although the mental health system is now gravitating towards deinstitutionalisation, the language about 'madness' has not changed. Those afflicted by 'madness', or mainstream society, do not have ways to talk about or deal with 'madness' that are not rooted in nineteenth-century asylum culture. Instead of a physical asylum, the current mental health system enforces a metaphorical one: a regime of daily medication, psychiatric involvement, and perpetual risk assessments, where any challenge to psychiatric 'authority' is labelled as a 'lack of insight', and thus a verification of illness. To return to Healy's statement that nineteenth-century asylum 'recovery' 'rates are comparable to those of psychiatric facilities today', it is clear that our current medicated, 'care in the community' model is not improving the quality of life of those deemed 'mad', nor is it impacting on the prognosis of such illnesses.[89]

The fundamental issue here – comprised of the enforcement of the sick role and the absence of suitable representation – is one of identity, more specifically *lost* identity. A large component of this is semantic, which I will address shortly. However, a considerable element of this is tied up into both popular culture – such as the examples I have explored – and the structures in place to deal with 'madness' (from psychiatric intervention to 'care in the community').

To return to the scenario I discussed earlier, in which the reader received a diagnosis of 'schizophrenia', one must really pause and reflect in order to appreciate the impact of such a label. What comes to mind when you consider the term 'schizophrenia'? The misinformed

[89] Healy, *Psychopharmacology*, p. 12.

social image of a split personality, like Jekyll and Hyde? Someone constantly in a state of delusion? Someone entirely out of touch with 'reality'? Someone *dangerous*? A 2012 study suggested that the two primary means of (mis)representing 'madness' in popular culture are as follows: 'to present mental illnesses in a way that promotes stigma (e.g., by conflating it with violence and crime) and/or perpetuates myths about mental illness (e.g., by presenting information that is inaccurate about, say, treatment and prognosis).[90] This is hardly a surprise. However, what we do not tend to consider is how these social misconceptions impact on those given such a label. Reflect on, for example, the myths and stigma surrounding 'schizophrenia': those labelled with this illness are immediately burdened with that baggage, on both social and personal levels. When you combine the disorientating experience of trying to align selfhood with this illness, with the sick role which erodes any sense of self that remains, the result is a fractured identity – if not one in a total state of dissolution.

This is further perpetuated by a lack of positive or relevant representation in popular culture. Representations of lived experience of 'madness' are misinformed and rooted in stigma. As an example, consider the myth that mental illness is associated with violence. When one enters the mental health system, one is constantly risk assessed: something which inevitably suggests the potential for *danger*. One absorbs the available information – *The Sun* headline I discussed earlier, for example – which also propagates the myth of violence. If there is no *non-violent* representation available for those living with 'madness' in the community – no point of reference for the illness which is not blazoned across tabloid headlines – would not the assumed merging of 'madness' and violence become internalised to some degree? Would this disorientating, new-found realisation that you may be *capable* of violence not then impact on how you interact with those around you? On how you engage with your friends and family? On how you view *yourself*?

[90] Jane Pirkis and Catherine Francis, 'Mental Health in the News and Information Media: A Critical Review (April 2012)' <http://www.mindframe-media.info/home/resource-downloads/other-resources-and-reports/?a=6322> [accessed 8 March 2015], p. 3.

There is hope. The charities Mind and Time to Change are dedicated to combatting stigma. Revered (and very privileged) celebrities have opened up a discourse on their personal experience of mental illness. We are – gradually – redirecting and reshaping some societal attitudes towards 'madness'. Some recognise that, for example, *The Sun*'s headline was a misinformed and tactless example of sensationalist journalism. The petitions and backlash provoked by this headline were significant, and tremendously encouraging. However, as we are stuck in an 'us' versus 'them' culture – the spectre of the asylum – in a mainstream context, we still do not quite appreciate how such (mis)representation impacts on those desperately trying to recover a sense of self after a psychiatric diagnosis. We are yet to offer viable alternatives, and thus entirely overhaul the societal discourse *about* 'madness'. This suggests that mainstream society is still not at the point of empathy. Using our current model and our current semantic foundation, we will never get there.

I do not believe that, as a society, we can ever truly empathise with those experiencing 'madness' until we acknowledge and deconstruct the political, psychiatric and popular discourses in place which continue to present 'madness' as a state of 'otherness'. We need to talk of 'madness' in *human* – rather than medicalised – terms. Writer and activist Jacqui Dillon argued that fighting for the rights and the voice of those labelled 'mad' is the 'last great civil rights movement'.[91] This starts as the whole process began: with language. As I have shown throughout this thesis, language is the foundation which establishes and sustains psychiatric politics, stigma and 'otherness'. Language both constructs and deconstructs identity. Language is the basis of representation. Language has built the master's house – or, indeed, the master's asylum. But language and representation are our only weapons in this final battle for civil rights.

[91] Jacqui Dillon, 'The Personal is The Political', in *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition*, ed. by Mark Rapley, Joanna Moncrieff and Jacqui Dillon (London: Palgrave Macmillan, 2011), pp. 141-57 (p. 156).

CONCLUSION

The Listening Cure

It is 2016. Stigma is not an alien concept. Actor, writer and comedian Stephen Fry recently publically discussed his personal experience of 'bipolar disorder'.[1] In an interview with *The Independent*, Fry explained: 'I want to speak out, to fight the public stigma and to give a clearer picture of a mental illness most people know little about'.[2] In April 2015, it was announced that broadcaster and campaigner Ruby Wax was to be awarded an OBE for her services to mental health, and was commended on 'her rare skill of being able to speak of the deepest and most painful things with openness'.[3] Known for speaking candidly about her own experience of 'depression', Wax established the Black Dog Tribe, 'a dedicated social networking community for mental health', with the intention of encouraging openness and halting stigma.[4] The Black Dog Tribe manifesto explained that 'us tribers believe that by talking more openly about mental illness, we can help one another, stop stigma and raise awareness. Our motto is: the more people we get talking, the more we will be heard'.[5] The narratives of such prominent, public figures with large fan-bases 'can potentially reach an audience beyond the "woolly liberal" sorts who you'd probably expect to criticise mental

[1] Fry has been described as 'one of Britain's best-loved actors and comedians'; his popularity is significant, as it allows him to be well-placed to talk of 'madness' in a mainstream context. See Johnathan Owen, 'Stephen Fry: My Battle with Mental Illness', *The Independent*, 23 October 2015 <http://www.independent.co.uk/life-style/health-and-families/health-news/stephen-fry-my-battle-with-mental-illness-416386.html> [accessed 30 October 2015].
[2] Stephen Fry quoted in Owen, 'Stephen Fry'
[3] 'Ruby Wax to be Awarded OBE for Mental Health Work', *BBC News*, 27 April 2015 <http://www.bbc.co.uk/news/entertainment-arts-32477545> [accessed 30 October 2015].
[4] Sane, 'Black Dog Tribe' <http://www.sane.org.uk/what_we_do/bdt> [accessed 30 October 2015].
[5] Ibid.

health stigma anyway'.[6] These conversations, vocalised by the likes of Fry and Wax, are making more and more of us aware of the importance of being able to talk of 'madness' as a personal experience, and how essential it is that we *listen*.

In October 2015, the Department of Health invested £660,000 in a national campaign to address and reduce mental health stigma in young people.[7] Sue Baker, the director of Time to Change, described the stigma faced by young people as 'life-limiting'.[8] Surveys conducted by Time to Change reveal 'that stigma prevents young people from doing the everyday activities that are part of teenage life […] 26% said negative reactions from others had made them want to give up on life'.[9] As a society, we appear to have acknowledged the devastating impact of stigma. Dialogues have started. Investments are being made. Educational programmes designed to target stigma are being developed. But how has this apparent awareness impacted on our everyday discourse – on the way we talk about and perceive 'madness' – conversations which have historically, as I have shown, reinforced stigma?

As I demonstrated in chapter one, the genesis of stigma can be found a two-fold language problem which established the assumption that 'madness' equates to 'otherness'. First, psychiatric language used to identify and demarcate 'madness' enforces 'otherness'; second, the language use of the 'patient' is pathologised. Psychiatric discourse, established as the 'authority' on 'madness', is a conversation which excludes and invalidates lived experience: as a result of this hegemony, personal accounts of 'madness' have been silenced. As evidenced by my Saussurean approach, taxonomy is the enforcement of signification, projecting the signifier (the label) onto the signified (the individual), thus burdening the

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[6] Dean Burnett, 'Did 2014 Mark the Beginning of the End for Mental Health Stigma?', *The Guardian*, 19 December 2014 <http://www.theguardian.com/science/brain-flapping/2014/dec/19/2014-mental-health-stigma-end> [accessed 30 October 2015].
[7] Information taken from Time to Change, 'New Campaign Set to Tackle Life-Limiting Mental Health Stigma Among Teens' <http://www.time-to-change.org.uk/news/new-campaign-set-tackle-life-limiting-mental-health-stigma-among-teens> [accessed 30 October 2015].
[8] Ibid.
[9] Ibid.

individual experiencing ‘madness’ with the baggage and social stigma latent in such terminology. The signified is *reduced* to the signifier: as Laing asserted, the application of taxonomy is a ‘social fact [and] a political event’.[10]

Examining taxonomy through a Saussurean lens does also offer some potential for change. Although the arbitrary and gradual evolution of language could move away from or disempower stigmatising terms, it is something over which we have little agency. However, Saussure’s claim that signification must also encompass ‘association[s] and coordination[s]’ offers more fluidity: instead of attempting to deconstruct and neutralise stigmatising labels, the context of this language can be revised.[11] Much as ‘darkness’ is understood in relation to an absence of ‘light’, so the meaning of ‘madness’ is established as a deviation from the social construct of ‘sanity’. ‘Madness’ is viewed in an oversimplified dichotomy: a legacy of psychiatric dominion. However, by challenging or even being aware of this problematic binary, ‘madness’ can be spoken of as a variant of ‘sanity’, rather than its antithesis. If conversations about ‘sanity’ alter, discourses of ‘madness’ shift alongside them.

Chapter two explored how ‘madness’ narratives are caught in a conflict between accessibility and authenticity. A personal account of ‘madness’ constructed in psychiatric terms is socially familiar and thus accessible, but delimits the individual to the residual ‘otherness’ imposed by hegemonic narratives. An account which rejects psychiatric discourse to communicate ‘madness’ is not limited to its vocabulary but is pathologised by psychiatry and deemed a ‘closed’ text: although authentic, the narrative is unable to be validated by a social audience. The expectation that a ‘madness’ narrative is ‘incomprehensible’ invalidates personal experience, and reinforces the dichotomy of ‘mad’ and ‘sane’. Any voices which may attest to the grey area in-between the Kraepelinian ‘sane’/‘insane’ binary are silenced by these politics. I have also reflected on how this dichotomy is evidenced in popular culture

[10] Laing, *Politics*, p. 100.
[11] Saussure, *General Linguistics*, p. 13.

today and how this reductionist approach continues to marginalise lived experience of 'madness'. 'Madness' does not have to equate to 'otherness' and silence: this assumption is not an inherent truth, but merely a social and psychiatric construct.

Some case study narratives included in chapter two further complicate this conflict between accessibility and authenticity by performing and ventriloquising the 'patient' role. In these instances, although the experiences of the self are constructed using sanctioned psychiatric vocabulary, the individual does not entirely submit. Although the self accepts the assumption of social and medical 'otherness', there is a personal victory: selfhood is not completely usurped and reconstructed to accommodate a psychiatric label and the concomitant 'patient' role. This simultaneous echo, and deflection, of psychiatric terminology is replicated in twenty-first-century 'madness' narratives, particularly by the Mad Pride movement.[12] Although far from a mainstream discourse, there is a significant reclamation of language: of using stigmatised terms such as 'mad' to construct an identity, form a community and make a political statement, without submitting to the role of disenfranchised 'patient'.

This thesis has exposed that the grassroots struggle to reclaim language to speak of the self, and to recover selfhood from the damage caused by language, dates back to the genesis of psychiatry. As illustrated by Poe's short story 'The System of Doctor Tarr and Professor Fether', 'madness' is a phenomenon of context: it is only after psychiatry established itself as the 'authority', the managing force, that 'madness' becomes 'other'. Although poignant and powerful, the fact that the likes of Mad Pride are still not acknowledged in mainstream culture suggests that this tactic has not yet destabilised the

[12] Mad Pride describes itself as 'the first great civil liberties movement […] of the new millennium', a 'survivor'-led campaign which is 'concerned with reclaiming the experience of madness and the language surrounding it […] language can be subverted and […] words derive their meanings from the contexts in which they are used'. Mad Pride 'mock[s] conformity, resist[s] "normalisation" and refuse[s] to be co-opted […] rejoic[ing] in madness from a standpoint of anger, humour and rebellion'. See *Mad Pride: A Celebration of Mad Culture*, ed. by Ted Curtis, Robert Dellar, Esther Leslie and Ben Watson (London: Chipmunka Publishing, 2000), pp. 7-8.

‘mad’/‘sane’ binary (a dichotomy which Poe himself tried to challenge in 1845). So what other possible solutions are available?

By exploring fictional representations of ‘madness’, discourses which inform and are informed by public perception, chapter three established the main tropes and techniques used to discuss ‘madness’ during the nineteenth century. Disconcertingly, much like the examples of popular culture examined in chapter five, mainstream representations of ‘madness’ seem unable to escape hegemonic discourse. Canonical texts such as ‘Maud’, ‘The Tell-Tale Heart’ and *Dracula* rely on psychiatric (mis)understandings of ‘madness’. Although these fictional representations act as a continuation of psychiatric hegemony, they do inevitably reflect on the individual in a psychiatric context, and thus on the politics of the ‘patient’/psychiatrist relationship. For example, despite the characters Renfield and Lady Audley being ‘othered’ by psychiatric forces, Stoker and Braddon are unable to present a ‘mad’ character without commenting on the reality of being ‘mad’ and being disenfranchised by psychiatry. The personal experience of ‘madness’ *is* acknowledged, albeit in an oversimplified and fictional manner.

‘Madness’ literature has the potential undermine the ‘mad’/‘sane’ binary by offering an intimate, first-person narration (such as Perkins Gilman’s *The Yellow Wallpaper*) or portrayals which have the potential to challenge hegemonic discourse (as found in Poe’s ‘The System of Doctor Tarr and Professor Fether’). Fiction can also defuse ‘otherness’ by portraying ‘alien’ states (such as hallucinations or experiences of multiple selves) in a way which allows the reader to relate or empathise. However, representations of ‘madness’ as consistently other than ‘other’ are few and far between. Chapter four further exposed the difficulties in trying to communicate ‘madness’ in a mainstream context, despite visual art being a medium that is, in theory, divorced from the politics of language. A ‘madness’ narrative cannot be validated by a social audience without being somehow compromised,

reduced or censored. As chapter five showed, mainstream representations of, and conversations about, 'madness' have not progressed since the nineteenth century, and are still stigmatising and damaging by virtue of relying on psychiatric discourse.

It is vitally important that we accurately portray mental illness: to destabilise dichotomies and eradicate stigma, to validate lived experience of 'madness' and to encourage those who need it to start a dialogue and seek help without fear of becoming 'other'. In 2014, Time to Change conducted a survey about how people responded to portrayals of mental illness in popular culture, specifically television dramas. Despite noticing trends of 'overly simplistic portrayals of mental health problems' and 'misinformation', the survey reported that '25% of those surveyed who had personally experienced a mental health problem were encouraged to seek professional help after seeing a character with similar issues' and '25% of those surveyed who know someone with a mental health problem felt prompted to contact a loved one, friend or colleague who has a mental health problem after seeing a storyline on the issue on TV'.[13] Imagine the dialogue that could be started, the help that could be accessed, the stigma that could be neutralised, if popular culture moved away from the 'overly simplistic' and erroneous and, towards the multi-faceted, the dynamic, the authentic, the *human* behind every mental health statistic.

Attitudes towards 'madness' are changing, albeit it at a glacial pace. In 2014, academic and writer Dean Burnett observed that 'those with mental health concerns do still have to deal with all manner of dreadful obstacles and ordeals on a regular basis; [but] there seems to be a growing agreement that *this is unacceptable*'.[14] This gradual shift can be charted in the Attitudes to Mental Illness 2011 survey conducted by the NHS. In the report, public responses are compared to previous results: for example, 'the percentage of people

[13] Time to Change 2014 Survey, 'Making a Drama Out of a Crisis' <https://www.time-to-change.org.uk/sites/default/files/Making_a_drama_out_of_a_crisis.pdf> [accessed 29 April 2016], pp. 6-8.
[14] Burnett, 'Beginning of the End'. Emphasis in original.

agreeing that 'Mental illness is an illness like any other' increased from 71% in 1994 (the first year this question was asked) to 77% in 2011.'[15] From 2009 to 2011, the percentage of those asked if they would feel comfortable talking to a friend or family member about their own mental health rose from 66% to 70%.[16] However, in some areas, the absence of progress is disconcerting. In 1994, 8% of participants agreed with the statement: 'I would not want to live next door to someone who has been mentally ill'; in 2011, that number increased to 11%.[17] Similarly, in 1994, 92% of people asked agreed with the following statement: 'we need to adopt a far more tolerant attitude toward people with mental illness in our society'. In the 2011 survey, only 86% agreed. Is this, somewhat paradoxically, reflective of progress – that, in 2011, we were *more* tolerant, and thus an attitude change was deemed less necessary? Have we convinced ourselves that we are tolerant *enough*? Has the work of organisations such as Time to Change – campaigns which condemn stigma – lulled us in to a false sense of security? Has it led us to believe that stigma has already been tackled – that the war has been won – when, for the one in four of us experiencing 'madness', the battle against everyday discrimination is still ongoing?

In 2014, I attended a conference in London centred on the theme of 'alternative psychiatric narratives'. During a roundtable discussion, an esteemed academic described himself as 'anti anti-stigma'. He felt that stigma was no longer an issue. I was astounded. If someone who has dedicated time to conduct research and write in the field of mental illness and representation believes that stigma has been eradicated, might those less informed also make the same false assumption? In chapter five, I mentioned that we are aware of stigma but only as an abstract concept. We recognise stigma as a theory but are not familiar with it in practice. This is because lived experience of 'madness' (and thus of being on the receiving

[15] National Health Service, 'Attitudes to Mental Illness 2011 Survey Report' <http://www.hscic.gov.uk/catalogue/PUB00292/atti-ment-illn-2011-sur-rep.pdf> [accessed 30 October 2015], p. 5.
[16] National Health Service, 'Attitudes', p. 5.
[17] National Health Service, 'Attitudes', p. 9.

end of stigma) is not part of the mainstream discourse. For the most part, we are hearing about stigma from those who have not experienced it. We are rarely encouraged to reflect on the role we may have played in this legacy of discrimination. We have never been made aware of the steps necessary to defeat stigma: we are not urged to take an active role, to reflect on our own attitudes, and to comprehend the impact of our language choices. This is a key purpose of this thesis: to reflect on and encourage agency and responsibility; to comprehend the political reality of being 'mad' and of being silenced; and to understand where stigma began and how it can be realistically and achievably challenged.

Throughout this thesis, I have shown the function of language in establishing and enforcing stigma. I have demonstrated how the language (and silence) of 'madness' is an enduring issue which is culpable for current societal attitudes from the nineteenth century to the twenty-first century: namely, the assumption that 'madness' is 'other', and requires psychiatric management. I have exposed the politics of the diagnostic process: how the allegedly 'mad' individual is reduced to and fixed to a linguistic anchor – a diagnosis – which reconstructs and dictates identity. The personal narrative is silenced in favour of psychiatric hegemony. Lived experience (an experience that could be familiar, with which we might, perhaps, empathise) of 'madness' is overruled by psychiatric discourse (the narrative which 'others' 'madness'). But what do these theoretical ideas look like in reality? As soon as the lived experiences of, for example, Wax and Fry enter popular currency, and give 'madness' familiarity, there is potential for society to have a point of reference for 'madness' which is not solely psychiatric or entirely 'other'. When engaging in conversation with someone on the topic of 'bipolar disorder', one may employ Fry as an example – a *human* reference point – rather than relying on psychiatric oversimplifications, damaging myths or misrepresentations from popular discourse.

By championing the individual experience of 'madness', we can undo the deeply entrenched pattern of silencing that this thesis has exposed. We know that one in four people will experience a mental health problem each year in the United Kingdom.[18] As I established at the start of this thesis, on average that equates to over thirty-five people in our immediate social network who experience some form of mental illness. We are surrounded by *experts by experience*. Encouragingly, this is now being recognised, albeit on a small scale. Mind invites those with experience of psychotropic medication to 'review' these drugs on their website: rather than relying on psychiatric discourses, Mind is not only acknowledging and listening to lived experience, but is also providing these narratives with a platform.[19] This has the potential to change how we find and share information about 'madness'. Imagine that you have recently learnt that a friend has been prescribed antipsychotic medication. Out of concern or curiosity, you research these drugs online. What if, instead of being bombarded with terminology which immediately evokes 'otherness' – 'psychosis', 'schizophrenia', 'hallucinations', 'mania', 'sectioned' – you were able to access and learn from the experience of someone who has been prescribed similar medication?[20] From the perspective of someone who has been medicated intermittently for fourteen years, I would much rather those around me asked *me*, rather than exploring the frightfully stigmatising psychiatric discourses which currently dominate available information.

If we allow a new discourse of 'madness' to permeate social consciousness, one of lived experience, rather than of psychiatric (mis)understandings, then there is potential for stigma to be entirely eradicated.[21] As I have already established, this new dialogue allows for information to come from those who are living through, or who have lived through,

[18] Information taken from Mind, 'Mental Health Facts'.
[19] See Mind, 'Help Us Improve Our Information' <http://www.mind.org.uk/information-support/review-and-quote-landing> [accessed 30 October 2015].
[20] All of these terms appear on the first page of a Google search for 'antipsychotic', conducted October 2015.
[21] Of course, an autoethnographic account of 'madness' is not new in the sense that these narratives have always existed. However, as these voices have either not been allowed to reach a social audience, or have been disregarded and thus silenced, they are – in effect – *new* to the mainstream social sphere.

'madness'. Mainstream dissemination and acknowledgement of the personal account of 'madness' challenges the problematic binary I established in chapter five. If those who fall in-between the twin pillars of 'madness' in popular culture, with controlled, incarcerated 'madness' on one side, and unsupervised, dangerous 'madness' on the other, find a voice, and are thus represented, then this binary opposition is rendered obsolete. This new discourse would also depict 'madness' as a spectrum rather than a dichotomy, as something fluid and unstable, a phenomenon 'relative to the place at which we stand'.[22] If lived experience were to enter popular currency, the presence of 'mad' voices would 'illuminate […] the myriad shades of humanity that lie between supposed black and white distortions between the mad and not-so-mad'.[23]

How do we achieve this? I have shown how firmly entrenched hegemonic discourse is, and how psychiatric politics have prevented us from accessing personal experiences of 'madness'. Is this sudden desire to listen somewhat naïve, or too little too late? How can our individual actions or even just our language undo well over a century of psychiatric hegemony? The first step is to recognise the role we have played in supporting and affirming psychiatric 'authority'. Whenever we employ the tools of psychiatry, often without explicit thought (the language *about* 'madness', the discourse of 'otherness' and judgement), then we are complicit.

As psychiatric (mis)understandings of 'madness' are embedded in our everyday vocabulary, it can be very difficult to identify instances where we are active agents, supporting hegemonic discourse. But whenever we imply that 'madness' is a state of violence, of unreliability, an absence of reason, indeed, anything other than *human*, we are echoing psychiatric narratives, and imposing judgement and silence. Whenever we employ a semantic field of 'madness' as an insult – 'bonkers', 'maniac', 'psycho' – we are further

[22] Richard P. Bentall, *Madness Explained: Psychosis and Human Nature* (London: Penguin, 2004), p. 117.
[23] Cross, Mediating Madness, p. 30.

estranging those who are living with and through ‘psychosis’, or ‘mania’, or any experience of ‘madness’, thus furthering psychiatry’s legacy of silencing the individual narrative. When we reduce and dismiss individuals to such labels (albeit less sanitised categories), we are merely imitating the psychiatric process.

The assumption that ‘madness’ needs to be ostracised (whether in an asylum or, in a twenty-first-century context, a hospital) is a trope established by psychiatric discourse. The conviction that ‘madness’ requires psychiatric management and, more often than not, medication is not an innate truth: it is something hegemonic discourse has taught us to believe. All that we think we know of ‘madness’ has its origins in psychiatric narratives: hypotheses established by those who, in the vast majority of cases, observe and study ‘madness’ without experiencing it. An ‘objective’ discourse written by the *watcher* will always lack empathy. We are taught to speak of and (mis)understand ‘madness’ as observers, mirroring the clinical detachment of the psychiatrist, but we are rarely taught to connect with experiences as fellow human beings.

Recognising the power of hegemonic discourse is the first step in challenging it. This thesis is intended to help readers with this initial step: to demonstrate how psychiatry established itself as the ‘authority’; how the conversation about ‘madness’ started by psychiatry reinforced this assumption; and how these politics have prevented us from accessing any other narratives about ‘madness’. Armed with this knowledge, I invite my reader to become an active force in deconstructing the assumption that only psychiatry can teach us about ‘madness’. This process is twofold: first, we must challenge what psychiatry has told us about ‘madness’. Second, we must acknowledge and learn from alternative narratives, primarily, lived accounts of ‘madness’, and celebrate the ‘authority’ of those who are experts by experience, not by observation.

Revolution begins with small changes. We need to regulate our own discourse, to ensure that when we speak of 'madness', we are not simultaneously silencing it. We must identify instances when we inadvertently use psychiatric tropes or assumptions, and reflect on alternatives. If we have never known any different, it is easy to take for granted the ability to speak and to be heard. We are able to make conscious language choices, although we often rely on entrenched signifiers. For example, when describing changeable weather, or erratic behaviour, we may employ the terms 'schizo' or 'manic' without acknowledging *why* we equate 'madness' with unpredictability (another trope of 'otherness' established by psychiatric discourse), or considering the ramifications of using psychiatric terms in such a casual fashion.

Part of this battle is challenging the growing trend to trivialise mental illness by employing psychiatric terms as adjectives: when someone particularly tidy describes themselves as '*so* OCD'; when nervousness is labelled as 'anxiety' or a 'panic attack'; when sullenness is called 'depression'; when moodiness is declared 'bipolar'.[24] From a semantic perspective, this could be deemed as a positive step: after all, mainstream use of these terms could potentially deconstruct taboos surrounding these historically 'othered' states. It is revealing that a condition such as 'obsessive compulsive disorder' is considered a quirky personality trait and problematically fashionable, to the extent that we, as a society, are increasingly keen to apply this label to ourselves. This trend has been described as 'a common form of hyperbole'.[25]

Previously, I examined how popular discourse informs our everyday vocabulary, and this is yet another example of the influence and disconcerting irresponsibility exhibited by the

[24] I appreciate that my inclusion of 'OCD' (an abbreviation) is problematic in an academic thesis. However, the mainstream appropriation of the initials 'OCD' shows how familiar the term is: a social audience will recognise the initials, and understand what they refer to. It is also an interesting neutralising strategy, almost as if it is being spoken of in code and thus not acknowledging the 'disorder' that the 'D' refers to.

[25] Kelly and Winterman, 'OCD'. I am, however, yet to encounter someone casually describe themselves as 'schizo' or 'psychotic' in the same way that someone might declare themselves '*so* OCD'.

media and other mainstream agencies. Journalist Ashley Fullwood recently observed that programmes such as Channel 4's *Obsessive Compulsive Cleaners* have distorted the trauma and suffering of the condition: 'while the media continues to portray OCD to be a beneficial trait of choice, the general populace […] will fail to grasp th[at] […] it's a disorder'.[26] On the one hand, these mainstream discourses enable us to talk about certain types of 'madness', and to view mental illness as a spectrum (or, indeed, an eccentricity or a personality trait). However, as I established in chapter one, 'madness' is already vulnerable to multiple and contradictory social and psychiatric misconceptions, and the manner in which terms such as 'OCD' have re-entered our everyday vocabulary causes further confusion and (mis)understanding. Policing the use of these terms may seem petty – or even irrelevant – but my concern is that it is the start of yet another social trend which prevents lived account of 'madness' from being acknowledged. On the rare occasions where I do talk about my own experience of what has been labelled 'obsessive compulsive disorder', I have to battle with entrenched social misconceptions and trivialisation.[27] Of course, of all the stereotypes attached to psychiatric labels, the assumption that I am clean (albeit 'obsessively' so) is not explicitly a damaging one. However, it is a stereotype which invalidates my own experience (which does not conform to assumptions in popular culture about what 'obsessive compulsive disorder' is), or belittles it (because 'obsessive compulsive disorder' is considered a quirk rather than a debilitating disorder).

Earlier, I discussed how psychiatric terms have taken on a semiological life of their own. This process cannot be reversed: when this vocabulary entered mainstream currency, psychiatry lost control of it, and this is an inevitable and organic part of language evolution.

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[26] Ashley Fullwood, '9 Things You Only Know if you Have OCD', *Metro*, 2 November 2015 <http://metro.co.uk/2015/11/02/9-things-you-only-know-if-you-have-ocd-5464505/> [accessed 2 November 2015].

[27] The predominant social misconception that I have faced is an assumption that the label 'obsessive compulsive disorder' mean that I am *just* tidy, picky, or fussy. This has led to my experiences being trivialised, as OCD is (mis)understood as a personality trait rather than as a disorder.

For now and perhaps for the foreseeable future, the assumptions that ‘schizophrenia’ is a split personality, that ‘psychosis’ equates to villainy and violence, and that someone who is sectioned looks like Asda’s ‘Mental Patient Fancy Dress Costume’ are likely to linger in our collective social consciousness. But the vitally important and very exciting redeeming feature of language is that it *continues* to evolve. We are shaping the discourse of future generations. We have shown that we can (to an extent) break down the taboo surrounding certain conditions: this was not intentional, but merely a by-product of the media’s dialogue. If this can happen by accident, what can we achieve by conscious effort? If we start conversations which acknowledge, validate and champion lived accounts of ‘madness’, we have the potential to shape future discourses. In a decade, a new generation will emerge to whom the personal experience of ‘madness’ is the first point of reference for what ‘madness’ *is*. The one in four of us will be the experts: psychiatric narratives will perhaps be complementary, but far from the ‘authority’. Psychiatric discourse of ‘madness’ will be *a* perspective, but not *the* perspective.

It is easy to overlook our involvement in supporting hegemonic discourse. It must be recognised that in our relationship to this dominant narrative, silence is still a form of consent. Whenever we hear someone disparagingly refer to another as ‘psycho’, and do not interject, the assumptions that it is okay to employ that term in such a manner, and the belief that ‘madness’ is a state akin to a damaging insult, are validated and reinforced. We are social beings. We regulate our behaviour according to what we understand is acceptable in our immediate context. In the microcosm of conversation, challenging stigma is achievable. When I question people on their language use, for example, when I challenge the common trope that the term ‘psychotic’ is a euphemism for ‘serial killer’, the most common reaction is one of surprise. This shows how embedded psychiatric discourse is: the belief that ‘madness’ is ‘other’ is *so entrenched* that the suggestion of an alternative approach is unexpected,

something alien. Most sanism is not overt.[28] But, as with sexism and racism, if mental health stigma remains unchallenged, it is endorsed and enforced by silence. Questioning the language of others does not have to be confrontational: it can, instead, be a process of education. I can tell someone how it feels when the term 'psychotic' is banded about as an insult, or a criminal category, when I take antipsychotic medication (and so, by extension, require medication so as not to be 'psychotic'). I can challenge, I can inform, I can suggest alternatives. To those with whom I converse, I can become a new *human* point of reference for what 'psychosis'/'neurosis'/'depressive'/'mentally ill' look like.[29]

Over the course of this thesis, I have identified several different approaches available when it comes to talking of and about 'madness', as potential solutions to overcoming stigma. As I have already established, the initial step is realising how hegemonic narratives have interfered with the reception of counter-narratives, as exhibited by this thesis. There are *other* ways to comprehend and communicate 'madness': models divorced from the 'otherness' imposed by psychiatric (mis)understandings. I have already discussed the necessity of understanding 'madness' as a spectrum. This model has been tremendously successful in breaking down gender binaries, and popular culture increasingly gravitates towards non-binary representations of gender and sexuality.[30] If gender can be something *other* than a

[28] 'Sanism' is a term I first encountered in *Mad Matters: A Critical Reader in Canadian Mad Studies*, ed. by Brenda A. LeFrançois, Robert Menzies and Geoffrey Reaum (Toronto: Canadian Scholars' Press, 2013). Although obviously less established than terms such as 'sexism' and 'racism', the growing trend for 'mad studies' offers hope that 'sanism' will become increasingly familiar, both as a phrase and as a concept.

[29] My own psychiatric labels present an interesting paradox. For the most part, were I asked to declare some form of diagnostic allegiance, I consider myself 'neurotic', as a result of elements of 'depression', 'anxiety', and 'obsessive compulsive disorder'. However, some parts of the latter have been interpreted as a break with 'reality', hence my experience with antipsychotic medication. Even in a psychiatric context which established the 'neurotic'/'psychotic' distinction, the disorder of human experience refuses to be pinned down to these oversimplified, broad categories.

[30] For example, the publicity surrounding American television personality and retired athlete Caitlyn Jenner's transition from male to female – including a documentary series dedicated to chronicling Jenner's journey – demonstrates that this less fixed way of viewing gender has become part of the social consciousness. In some respects, Jenner's transition from one label (male) to another (female) does uphold the gender binary (although the popularity of gender-fluid celebrities such as model and actress Ruby Rose and model Rain Dove challenges this further). However, the ability to move between labels – and to choose one's own label – is revolutionising mainstream representations and understandings of gender. Why would this model not also work to destabilise the 'mad' and 'sane' dichotomy?

series of dichotomies, can we not also be fluid in our ‘sanity’ as we are with sexuality? Can, as Lady Audley explained, one’s mind be perceived to ‘regain […] its just balance’ after an experience of ‘madness’?[31] Can one move from the label of ‘schizophrenia’ to the ‘norm’ of ‘sanity’, without the qualifier ‘in remission’?

There are binaries within binaries. There is the ‘sane’/‘insane’ dichotomy, perpetuated by psychiatric discourse, and which has established a binary of ‘us’ versus ‘them’, encouraging society to ‘other’ ‘madness’. As chapter five revealed, this is a legacy of asylum culture. I have shown that mainstream representations of ‘madness’ are also subject to another binary, meaning that lived experience of the vast majority of those labelled ‘mad’ (those who fall in-between these categories) does not enter popular currency, and remains unacknowledged. We need to instigate a conversation which speaks of lived experiences of ‘madness’, rather than a dialogue of archaic dichotomies which are, at best, reductionist and irrelevant.

In chapter five, I also identified another issue which has a drastic influence on the prognosis of ‘madness’, and has severe ramifications for those labelled ‘mad’: that of the sick role. Identifying, never mind solving, the problems latent in the current mental health system can be daunting, and it can be easy to feel resigned and to assume that this is a realm in which we can have little direct impact. However, we should not understate the positive impact that challenging language (and thus stigma) can have. I established in chapter five that a large part of the sick role was fractured identity: damage caused by the enforcement of a psychiatric label, and the social baggage associated with that label. If, using the approaches I have established, we were to destigmatise these terms, or, at least, to neutralise them, then the impact on the self could be minimised. If ‘madness’ is, instead, perceived as a transient,

[31] Braddon, *Lady Audley’s Secret*, p. 345.

temporary state – to and from which one can move fluidly – then previous notions of identity would not have to be entirely dismantled and rebuilt to accommodate a psychiatric label.

Talking *about* talking about 'madness' has been a difficult journey for me. Writing about being more than one's psychiatric label has, inevitably, made this thesis very personal, and has forced me to reflect on my relationship with *my* 'madness'. But I cannot preach about how vitally important it is for us to listen if I, myself, am unable to speak. Talking of 'madness' is – at present – a form of self-exposure, a kind of 'coming out'. This is because it is assumed that 'sanity' is the 'norm', and so to reveal oneself (or, indeed, be revealed) as 'mad' is to be burdened with the stigma of being something *other* than everyone else. But statistics are on our side. When I talk of my 'madness', I am only 'other' to the three out of four without personal experience of mental illness. And if any of the 'sane' 75% of the population are capable of empathy, of listening, then the 'us' versus 'them' binary which has historically enforced silence can be entirely deconstructed: 'madness' can truly be accepted and understood as something other than 'other'.

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